MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Embassy Suites
Chevy Chase Pavilion
4300 Military Road, N.W.
Washington, D.C.
Thursday, July 15, 1999

The meeting in the above-entitled matter convened, pursuant to notice at 10:37 a.m.

COMMISSIONERS PRESENT:

GAIL R. WILENSKY, Ph.D., Chair
JOSEPH P. NEWHOUSE, Ph.D., Vice Chair
BEA BRAUN, M.D.
SPENCER JOHNSON
PETER KEMPER, Ph.D.
JUDITH LAVE, Ph.D.
DONALD THEODORE LEWERS, M.D.
HUGH W. LONG, Ph.D.
FLOYD D. LOOP, M.D.
WILLIAM A. MacBAIN
JANET G. NEWPORT
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
GERALD M. SHEA
MARY K. WAKEFIELD, Ph.D.

P R O C E E D I N G S

DR. WILENSKY: Welcome everyone. We're in our not formally scheduled part of a summer meeting to discuss the graduate medical education recommendations and framework for our August report. Obviously, this has generated a fair amount of interest on the part of the public and we welcome people here during this part of our discussion. There will, of course, be opportunities for public comment during the day. We haven't decided yet, in part on how long the discussion appears to go and how we break up this discussion, as to whether we'll do more than one public comment or wait until the end of the day for the public comment.

We have some issues, some general issues that we want to discuss in addition to the specifics about the report, and I thought maybe what we can do is start the meeting with a general discussion about issues of what we see being in our August report and the context of whether we want to have a discussion about what we anticipate following the August report in terms of additional reports, either as stand-alone reports or as a part of our March payment report

for the year 2000. We don't need to make a decision about whether we will have a second stand-alone report or have it part of other reports, but the issue of how we frame the presentation that we are going to be making to the Congress next month I think is an important issue.

So why don't we start with some discussion about how we want to position the report that we are going to be making, in particular because I think as all of you are well aware, that the specific implications for what payment policy changes would look like will require some additional work. Some work has been done, but some additional work that will look at alternative models for making the estimation of looking at the cost associated with providing care in teaching hospitals, and what that means for additional cost to patient care, and how it might be distributed, et cetera.

And that when we have a larger amount of information available in terms of what the empirical implications are we can also discuss some of the specifics, although we can have a general discussion now, about the desirability of phasing in, the various strategies for phase-in that have existed in the Medicare program and that

this commission and its predecessor commissions have considered in the past when they're talking about that in general discussion.

MR. MacBAIN: I think in looking over the draft that we've got before us now, I'm most comfortable with it if I view it as the first draft of what would be the first chapter in a more extensive report dealing with the broader mandate in the Balanced Budget Act; a chapter that discusses a change in the theoretical approach to graduate medical education and how we look at graduate medical education, but with subsequent chapters to come dealing with policy recommendations.

It seems to me that what we have here is a different approach to the issue based on good economic theory, but I'm looking for additional chapters to provide some empirical substantiation for that and some simulation of what would likely happen. But not simply releasing this by itself and saying, this is the report without indicating it's preliminary, it's a first step, it's the first chapter, and it's a change in the construct but not necessarily a set of specific policy recommendations.

DR. LAVE: I assume we're going to go through some

general overview comments and then come back.

DR. WILENSKY: Yes.

DR. LAVE: My general overview comment is that I think we need to spend more time laying out how we got where we got, and what the full implications of this are. I've been listening to the discussion. It seems to me that the model that we're using an economic model that talks about how it is that the residents -- the cost of education is really borne. What we don't talk about, and the more that I think about it the more critical I think it is, is sort of that the competitive model assumes a competitive product market where the product -- let me come back to what the problem is.

You have to be able to sell the product, so we have to think about what the product is. As I've been thinking about -- it works, it seems to me, in certain environments for certain types of things and maybe it works best for graduate medical education and academic teaching hospitals. But we are clearly asked to think about different settings. So I think that we have to be concerned about how the different products in which the residents in fact are involved are going to be priced to think about the

full implication of this.

The way that we are thinking about it at the moment is really on -- sort of a reflection of a cost-based model. And I think the best model for dealing with this is actually in the hospitals. But I think about the conversation that we were having before people came in which had to do with geriatricians. But many of the products that geriatricians sell, where they would be getting their training, so to speak, are things like geriatric assessment: various kinds of products for which in fact we don't have a very good market or a very good price associated.

DR. ROWE: Or any payment.

DR. LAVE: Or any payment. This is really what I'm getting at, is that it seems to me that the best -- that it works reasonably well for the hospital setting, and I concerned about the fact that it may have implications for the practice of medicine that at least we need to discuss in terms of how it is that people in fact are going to be trained, because it all involves the product.

I'm being terribly inarticulate, but I think that we have to be clearer about how this model that we are basing our recommendations actually can be applied to the

health care arena, and what the implications are of applying it to the health care arena. As I said, I think that in the past --

DR. WILENSKY: Judy, let me just back up. It strikes me that your issue -- and we clearly need to come back to it -- is with regard to recommendation five, a very specific recommendation.

DR. LAVE: Okay, I have another comment that I want to make.

DR. WILENSKY: I'm just a little concerned that we start with a more general level on this issue.

DR. LAVE: My sense is that the recommendations that we currently have can be very easily transferred to a framework. That that is not a -- the recommendations really are a framework for thinking about things, and that we may be more comfortable talking about a framework. But they are so unspecified and lack so much detail that they really are consistent with the framework approach as opposed to a recommendation.

MR. JOHNSON: I won't belabor this other than I'd say, Judy, I'm not sure we've demonstrated that this works best for teaching hospitals. But I think overall in terms

of the report I would be more comfortable if these were not recommendations and were put forward as a conceptual framework with our thinking, identifying the issues we hope to address here. Then also even raising in the report some of the questions that have come up, and the fact that we'll be back when we have the analytical basis to form actual recommendations and see how this concept has played out.

DR. ROWE: I'd like to address -- I certainly agree that this is a conceptual framework. It's going to attract a lot of attention and analysis and response. I think if we put it in the framework of a conceptual framework or introduction -- I think it's been a year since I used the word prolegomenon, so I'd like to get that on the record -- that that's really where we are. I find it very stimulating, and I'm still trying to get my head around it, and I think Joe has made a real contribution here.

I'd like to address the conceptual issue with respect to education. As I understand it, the proposal basically says, we're not going to pay for -- the Medicare program should not be paying for education. It should be providing access to high quality, efficient services for the beneficiaries. So we're going to get rid of this education

label and we're going to have an enhanced patient care label. There are people, of course, who would be very concerned about that because they think that the educational piece is core from a conceptual point of view.

In listening to what Spence says and listening to our prior discussion about geriatricians reflected in Judy's comments, I wonder whether or not it might be appropriate for us to include in the conceptual framework a concept or a statement that the Medicare program might appropriately influence education in an indirect way.

That is, if the Medicare program policies are constructed in such a way to enhance access to what we think are important services that are currently not fully available, either by pricing or whatever else, in order to facilitate in this market-driven approach we're taking, facilitate the availability of these services which we believe are valuable for the beneficiaries, then presumably people have to get educated in those services. You have to train those geriatricians or something.

So that it would be appropriate for us to recognize that Medicare payment policies would have an effect on the educational process without directly

subsidizing, if you will, the education.

DR. WILENSKY: Do you just a doubt in your mind that if there were substantially increased payments for geriatric services that Medicare would have go subsidize a geriatric training program as opposed to having that pop up because people realize that this is now an area in which there was not only "need" but there was a way to get payment? The notion isn't that there is a problem in getting it supplied because there's some problem in the competitive supply --

DR. ROWE: I think quite frankly, Gail --

DR. WILENSKY: But it's just a question of what the services are paid for.

DR. ROWE: Let me respond to your question because I think that -- the problem is that the geriatric training programs are funded in a different way than the geriatricians. Currently, there are a lot of geriatric training programs in the United States which are vacant. There are more geriatric training programs available than there are good applicants.

DR. WILENSKY: Doesn't surprise me.

DR. ROWE: So we would not get, I think, requests

to fund the geriatric training programs. I disagree with you there.

The problem is that once somebody is done with the geriatric training program -- and there have been a lot of foundations, Hartford and Brookdale and others that have funded these. They can't make a living. That the payments for the services that the geriatricians provide are not adequate. So there is a disincentive to go into geriatrics unless you're a trained internist or family practitioner.

So what I'm saying is, that if the Medicare payment policies were such that they adequately compensated people for these comprehensive geriatric assessments that might take an hour and-a-half to do and they get paid for "one visit" that kind of thing, or end of life care, that would then have a beneficial effect on education of that group of people because there would be an incentive to go in. That's what I was saying.

DR. LAVE: Jack has said very nicely what it is that I was trying to say, and that we don't talk about in the report, which I think is very critical to talk about in the report. That is that in fact that we have to recognize in the report that the workforce will be contingent upon

what it is that is paid for in this society, and that we in fact are interested in the Medicare program. And that in fact if we do not believe that there are an adequate -- if it is not believed that there are enough geriatricians around, which I think we have to address directly, the question is, do you want to address that through fiddling around with the hospital payment policy or worry more directly about the products in fact that geriatricians would produce?

I think that that's what I'm saying. There has to be some linkage about the overall environment within which these services are being paid, and we miss all of that kind of discussion and what it is in fact that we are doing in terms of this report. I think that that is why it is that the whole discussion about how we think the system works has to be elaborated in much more detail than is in this report.

The model of graduate medical education and why it is that we think that paying for products, which is what we are talking about, paying for products produced by graduate medical education, will in fact generate the right supply is something that has to be in here and elaborated. And I think some examples about where people see problems, like

problems with pediatricians, or problems with geriatricians, is probably not because we don't pay for training adequately. It's because we don't pay for the services that they provide.

DR. ROWE: That's a distinction.

DR. LAVE: And I think that has to be in here very clearly.

DR. WILENSKY: I'm going to let this discussion play out just a little more. Then I want Murray to take what has started off and to back up so we can bring our audience with us in terms of what the discussion is.

DR. NEWHOUSE: On this point that we've been discussing here, I have two points on this first discussion. We need to keep in our minds the distinction between the question of what the program should do, the overall goal, and the question of what the current GME payments in fact are doing, or are paying for. It seems to me that latter -- we have recommendations that are at both levels. Or the framework, let me put it that way, really goes to the second point: what in fact the current GME payments are doing.

What we're saying is, they're really paying for a different product at teaching hospitals, a different patient

care product, and we're willing to recognize that. Now there's a whole other, almost infinite raft of issues about what the program should do beyond that that go to like, what should we be doing about geriatricians and so on? But I think it will help us if we keep the question of what the current GME payment, which this report is about, is doing, separate from what the broad Medicare program should do.

Then to the larger issue about, do we have recommendations or do we have a framework? I think what I read this as is saying, we are recommending a framework. What I don't buy is that we need numbers to do that. It doesn't seem to me that the numbers dictate the framework. It seems to me that the framework dictates the numbers. That is, we have -- I understand that people, of course, will be interested in who wins and who loses. That's a different issue.

But the analogy it seems to me is with the national income and product accounts. We set up definitions of what constitutes consumption, what constitutes investment, what constitutes government spending and so forth, and then that dictates the numbers that the Department of Commerce comes out with every quarter on what

is consumption, what is investment, and so forth. The numbers don't substantiate the framework. There is no way I think to substantiate the framework empirically. We say this is the framework and the numbers will fit into that framework.

DR. ROWE: But our role, traditionally I thought, was not just to create a framework but to create the numbers.

DR. NEWHOUSE: We will create the numbers. The issue is, can you sum up -- do the numbers in some way validate the framework? The answer is, I don't think so. I think the numbers will be the numbers.

DR. WILENSKY: I think we do need to be very careful in indicating that this report will be part of one or more follow-on reports and the kinds of information that will be available in the follow-on report. But the issue about -- and I guess this is a question that each of you may have to ask yourself is that is your support of how we look at this issue of trying to make payments for enhanced patient care so that patients will be able to get access to services in places that we know are more expensive? That's really where we're at now.

Is who's the winner and who's the loser going to -- is that going to influence whether you believe this is a better way to think about this or not? I think that Joe and I are saying that this is an approach that we have been talking about now since April. There are a lot of ways that you can cushion what happens to losers in terms of limit in any one year, of holding them where they are now and letting the world grow to the new place, of taking two, five, 10 years. There's already some issue about whether 10 years was really enough for the capital payments.

But whether or not how we're thinking about this is a better way to think about payments, whether it makes more sense, whether it actually recognizes in part some of what has been going on and what we want to make sure happens, I don't know that the numbers -- I agree with Joe's concept. You can look at the empirical implications of what these distributions will look like when you change them, but it doesn't validate whether this is a better way to look at the issue.

That's really, I think, what we're here today to talk about once again is to say, are we now comfortable saying, this is how we're looking at this issue? And the

implications that it has are in some -- there are some specifics we can do now, but there are a lot of, here's what we would specifically recommend with regard to payment changes that will require three or four months of additional work.

DR. BRAUN: We've been talking about training of geriatricians as this conversation went on, but I'm wondering if we don't have a much broader -- Medicare doesn't have a much broader responsibility, which will fit into enhanced patient care, of young physicians and other health professionals actually learning how to take care of older patients; people that can't see as well, that can't hear as well, that don't brain process as fast. That certainly is part of enhanced patient care in a teaching hospital.

I'm wondering if we shouldn't maybe make that explicit as we're talking about enhanced patient care. But there is a difference in treating older people and hopefully all physicians, not just geriatricians, will learn through this experience in a teaching hospital.

MR. MacBAIN: I agree with what Joe was saying, but I would like to see what he was said distilled and made

part of this report, say explicitly that what we're recommending at this stage is a change in the framework, a change in the way we think about graduate medical education. And based on that change, in future chapters we'll deal with some specific policy issues. We're not ready to do that yet.

Also in terms of the numbers even at this stage, I'd really like to see if staff could take a look at the question of whether the economic theory underpinning this change is itself amenable to empirical validation drawn from teaching hospital data. I was talking to Craig about this earlier a little bit and he thought maybe the New York experiment would yield some valuable data, and I don't know if there's other sources as well.

But it would be helpful if we could find some way to substantiate the formula that was in here somewhere that the economic value derived by the hospital from having residents is at least equal to the cost of having the residents, in terms of the direct teaching cost and their salary. If we can demonstrate that, it will make it easier for people to understand the economic theory underlying this and I think it will help solve the concept more

realistically. But for stage one, to go back to what Joe said, if we can distill his remarks and make that part of one of the first couple of paragraphs it would make this easier for me to get behind.

DR. LOOP: I'd like to see a little bit less of the philosophy, particularly with regard to the analogy to the competitive labor market. I don't think graduate medical education really fits into that model. I think that the document also ignores the need to train physicians. Because one of the best investments that we have in America is the funding of science and graduate medical education, because from those two aspects come all the advances in medicine.

The other thing in reading through this that struck me is that one of the big problems that is not easily seen in this draft document is the problem of disproportionate payment right now. This is what we have to get to is a fair national payment rate. I would like to see a statement of the problem at the beginning of this, after perhaps the preliminary chapter. The problem is disproportionate payment, and that eventually has to get smoothed out, no matter what you call it.

DR. WILENSKY: Do you want to talk a little more about what you're thinking about it?

DR. LOOP: You have folded the DME into the IME, and in effect that could be a fair national payment rate.

DR. WILENSKY: Maybe we'll talk some more about what else you're thinking about when you talk about fair national payment rate.

DR. ROWE: Can I ask a question? Floyd, I think there's been a lot of concern about the variability in payments from region to region and one type of institution to another. I think it would be fair to say that variability, per se, is not evil. It depends on what its basis is, whether it was politically motivated or what. If the variability is based on cost, or in fact on audited reports or on a formula which was agreed upon that was based on some expenses, then that's true variability.

I would expect what you're saying is that we need to make sure that the variability is reflective of the actual expenditures rather than some other elements.

DR. LOOP: It's reflective of the cost, and the variation should be related to local factors.

DR. ROWE: That's what I mean, local factors

including wages and other factors.

DR. LOOP: Correct. There has to be some variation.

DR. LAVE: I think that I agree with Joe that this is an appropriate framework for thinking about how we ought to be incorporating payments for graduate medical education and how we have shifted our way of thinking about this. It seems to me there are some principles that fall from payment out of this, and then there is a discussion about alternative ways that this can be implemented. We have some discussion about that in there, and we may want to raise this.

I think it might behoove us, as I listen to the discussion around the table, to maybe have a section that says, this really is fundamentally different from the way we have thought about this in the past. Because this is extraordinarily, fundamentally different from the way we have thought about it in the past, because the concept of direct graduate medical education totally disappears, and with it any -- about why is it we're paying for more or less or anything else. I do think that that has to be included in this report, because as I listened to the discussion

around the table, we really veer in and out to the fact that we've changed our framework, but maybe we haven't quite changed it.

So I do believe that there should be a section that says, this is the way we've done it in the past. These are the implications about how we've done it in the past. These are problems that people have seen with the way that we've done it in the past. But let me tell you, we are asking you to change your mind-set about how it is that you think about this problem, and it probably won't be helpful to switch that much back and forth between the two concepts. That has to be a very significant part I think of what we are doing.

DR. WILENSKY: And as we can see, to keep reminding people the reason that we're now making a recommendation is, this is what we're trying to do. We're not trying to do something else.

DR. LONG: I just wanted to underline a couple of things that have been said. First, this whole notion of a paradigm shift, a sea change in thought is the centerpiece of what I think we've been up to for the last several months. This notion that the way we enhance access to

quality care for our beneficiaries is best achieved through paying for what it is we want, creating demand, supply will follow in the kind of economy that we have. Simply subsidizing supply doesn't do it. You're pushing on that string.

This notion of a dramatically different mindset, a completely new framework, I can't imagine what would better fit under the label that I have in my head under the word recommendation. Recommendation to me doesn't mean legislative language or specific numbers. In this sense, we are making a recommendation that asks the legislative and executive branches of this government to change the way they have been thinking since 1966.

I think that is exactly what a recommendation ought to be.

MR. SHEA: I like a combination of what Bill and Joe were saying about what this is. I would say that we want to put forward, or we are putting forward, or we're recommending a framework for looking at this. To me that implies that we might want to back off some of the specificity in the recommendations because I'm just not sure that you get from A to B, or we get from A to B, in this one

document.

I do think that it's important that the notion of paying for patient services, appropriate patient services, include in an explicit way the notion of education and preparation of the right kind of practitioners for that population. I thought Bea's point was very good, not just the geriatrician but the right kind of preparation for practitioners across the board who will encounter these beneficiaries or who the beneficiaries will encounter in the course of getting those services.

And then lastly, I think we should just be careful in how we phrase this concept, and in particularly in some of the phrasing where we try to point out what's not in this concept, so that the phrase not fulfulling broad social objectives, I'm not sure is useful in this context. And then specifically some of the points about uncompensated care, as we were talking about before.

I think we should try to stay with defining what we're trying to do here, because it's another big step to then say and this doesn't mean all these other things. Because right now some of those other things are mixed in here. And if we had the freedom to redesign the whole

situation, sure, that would be one thing. But we have to think about this as how it will be read in the context of current policy and current operations of the program.

MS. RAPHAEL: Since I'm fairly new to this I'm trying to synthesize what I think I'm hearing. What I'm hearing is that we're trying to make Medicare a more effective program and make sure that the dollars are used to attain what we want to attain in the program and that, in fact, GME dollars pay for a differentiated product at teaching hospitals, and we're trying to capture the contribution that residents make to that differentiated product.

Okay, then I guess I need to better understand the relationship between that differentiated product and residents, because I'm not entirely clear on that.

The other thing that I'm not entirely clear on is this issue of whether or not, by the enhanced patient rate, we can indirectly in fact affect educational policy and what happens in our educational institutions.

And in line with that, if Medicare detects either access problems or determines that there are ways to better deliver care, how would that somehow be incorporated into

the enhanced patient rate and kind of purchasing behavior.

So that's where I kind of feel I need some clarification.

DR. NEWHOUSE: Let me respond to this last point Carol raised first. We're not trying to isolate the contribution the residents make. We're saying -- think of it as the simplest case, which is not the real world, that most teaching hospitals are alike and most non-teaching hospitals are alike.

Then if we were back in '84, and we were setting up PPS, we would have probably just said well, we'll take average costs among teaching hospitals and that will be the rate we'll pay teaching hospitals, with wage adjustments, and so on and so forth.

And we'll set an average rate for non-teaching hospitals and that's what we'll pay them, much as we did for hospitals in rural areas versus cities, and we just averaged across those groups.

Now in fact, the real world is more complicated because teaching hospitals aren't mostly alike. They vary systematically in their costs by the number of residents they have. That just happens to be true empirically.

Whether it's got anything to do with residents or not is another issue.

So what we did, instead of just taking an average across all teaching hospitals, we said well, we'll vary the amount more we give you by the number of residents, because that's how the costs seem to vary empirically.

But what we think this is paying for is that kind of product systematically differs by that but it needn't be causal with the resident.

Let me make some comments on the earlier discussion. Bill asked could good numbers validate the model? If they could, that would help. Well, I think all we can say is what we can say about any model, which is that the data that we have are consistent with it and the models can only be refuted with data.

What's consistent with it is that after we put in the system, the number of residents went up markedly, and actually length of training went up, too, which could have for other reasons. But the model would have directly predicted that, that hospitals would have shifted up their demand for residents. It would also have made a second prediction, which give the fact that U.S. residents are in

relatively fixed supply because they're determined by the number of graduates of U.S. medical schools which didn't much change, that to increase their residents they would have had to get more IMGs, which they did.

So at least we have two empirical facts that seem consistent with this model. And I don't know of any that are inconsistent with it, but maybe there are.

On the competitive labor market, I'm not sure what Floyd had in mind by saying it wasn't, but we do have 1,500 plus or minus teaching hospitals around the country kind of bidding on 20,000 plus residents a year, which seems that the first order that that would be a reasonably competitive labor market. I say the teaching hospitals aren't collaborating in the wage offers they make. Or if they are, maybe the Justice Department would like to know about it.

DR. ROWE: We're not, we're not, we're not. That's not what he meant, he didn't say that.

[Laughter.]

DR. NEWHOUSE: My comment on the variability of the costs and what we want to pay for, I mean this is certainly an issue with graduate medical education. I have two comments to make on it.

One is that the variability that we're, in fact, paying for goes back to variation in '84. I mean, admittedly, the costs were audited by the issue is in 1999 do we really want to pay for variation in 1984?

But the second point is that if these are patient care costs, this is actually I think the more important point, that the whole philosophy of the prospective payment system is to average out the variation across hospitals in patient care costs. We pay an average weight in a DRG subject to wage variation and so on and so forth. But the whole philosophy is to average across institutions.

So it seems natural, in that context, to also average these costs across institutions. At least we would be creating an exception for a particular class of costs, which I don't know why we would do that.

And then finally, on the discussion about the training of the work force and elderly patients and so forth, I must confess to have some misgivings about that. I mean, what we're really talking about is now the quality -- or I would call it the quality and weight -- of graduate medical education.

I don't think HCFA, as the executive branch agency

for administering Medicare has any, or very much, competence to deal with the quality of graduate medical education. And I don't know that we should want them to get into that business. But people again could enlighten me about that.

It is clearly the case that how we pay for this is going to affect how a teaching hospital behaves. As I just said, we think that's happened. And there's no reason we ought not to try to anticipate that in the policies we set out.

But some of the comments and some of the discussion at least seemed to verge into we were actually going to -- HCFA would go into institutions and look at what was going on their graduate medical education program. I don't think that's what we intend.

DR. KEMPER: My first comment really relates to what Gerry said about framing of the report and how broad it should be. I think we ought to stay focused on A, a framework; and B, for graduate medical, thinking about that and not try to lay out the broader principle for what Medicare ought to be paying for.

That is, get into the issues of uncompensated care and broader issues that go beyond this. Because it seems to

me it's something we don't have to deal with in this context. It's something about which there would be a fair amount of discussion here. I think it's a lot simpler if we stay focused on that.

It's not a question of a particular recommendation or a particular paragraph but I think it pervades the document as it is right now. So I guess that's one thing.

DR. WILENSKY: Can you clarify what you mean, as it's now drafted it does pervade it or it should?

DR. KEMPER: It does pervade it now and I do not think it should. I think we ought to take out the sort of broader context of Medicare should not be concerned about uncompensated care and research as part of a broader Medicare policy. Because it seems to me that gets beyond the scope of what we're trying to deal with here, and unnecessarily so, particularly in the case of uncompensated care. I find myself not wanting to go down that road, at least in this context. That gets us very close to talking about DSH and a very different set of policy issues.

Secondly, I guess the one area where I think we ought to say more, or at least two sets of issues that I think are very important that we don't really speak to in a

practical way, is what about other settings, what does this framework mean when we talk about other settings? The way I read this, we're real clear that what it means for inpatient hospital care, we change what's in the costs to include the direct cost and we re-estimate the relationship that's there.

But I don't know how this plays out with respect to other settings, the outpatient. There's some mention of accounting problems, but that's a mouthful. What about other settings outside the hospital system altogether? How does this affect those sorts of issues?

And I think they're mentioned here but I think those are very important issues that I don't exactly see how the framework is going to play out, and I don't see how that there are likely data there, how we're going to make a judgment about whether value exceeds the higher cost in those settings.

So I think that's something that could be given more attention in the document. Related to that is other professions. How do we make those judgments about what other professions and whether the value exceeds the additional cost of those training programs?

I don't see my way through from the framework to even where you would go with that, at least from this document.

DR. ROSS: As people in the audience can see, we started out today without staff presentations and moving right to commissioner involvement and it all went downhill from there. I wasn't expecting commissioners to be quite so caffeinated so early.

[Laughter.]

DR. LAVE: We all read our report.

DR. ROSS: And I'm pleased. What I wanted to do is try and review the bidding a little bit to remind ourselves and the audience of why we're here, because the discussion is delving a little bit into specific recommendations and I think we should review a little bit of how we got to this point.

One theme that has emerged, both in our preliminary meeting, and then we've started to continue with this a little bit here, is this a report that stands by itself? Is it a leg on a larger journey?

And I wanted, in honor of Jack who's always trying to improve our vocabulary, bring a quote that I think

describes this. This is from a late British prime minister in 1942. This is not the end, and it is not the beginning of the end, but it is perhaps the end of the beginning. This is not our final discussion of GME.

I would like to, very briefly, review for everyone again what our mandate was, and a little bit of the process, both in terms of procedure and how we got here and some of the principles that are feeding into the commissioners' discussions. I think we've gone straight to some of the draft recommendations that the audience can see in the handout, but they haven't seen the whole paper.

Our mandate, your mandate, from the BBA was to examine and develop recommendations on whether and how Medicare payment policies and other federal policies regarding teaching hospitals should be changed. MedPAC was given a lengthy list of topics to consider, including children's hospitals, pediatric residencies, nursing and other allied health, international medical graduates, dependents of medical schools on service generated income, changes in the aggregate supply of physicians, other implications for teaching hospitals, methods for promoting an appropriate number, mix and geographical distribution of

those professionals. And at some point or another, over the past two years, or my past 17 months, all of these issues have been touched on in our public meetings.

For the audience, the deadline for submission of MedPAC's report was two years from enactment of the BBA, which would be August 5th, 1999. That mandate included consultations. As you know, we've taken that very seriously. We've discussed GME at virtually every meeting since the commission's inception. We've had a panel of experts to review the initial work plan and to raise any issues that they might not have included in that work plan.

We've sought input from 200 organizations and other interested parties. We've received letters from 50 groups on their views on policies. And Gail and Joe and I can attest and others, that commissioners and staff have met frequently with interested groups on this.

So I think many of the ideas that we're discussing and the discussions we've had around the recommendations, people have heard these ideas even if they haven't seen the specific words at this point.

All of this discussion began a year-and-a-half ago with three questions. What is Medicare buying? What should

it be buying? And how should the program pay for what it buys?

The first of those questions has been the subject of the Newhouse Epiphany as its come to be known. Medicare reimburses teaching hospitals for two types of reported costs. There's the direct cost or stipends, faculty salaries, and overhead that's allocated to the residency programs. And there's the indirect costs associated with higher patient acuity, enhanced patient care that is more intensive and technologically sophisticated, clinical R&D that gets undertaken.

And over the past several months, we interpret the commission to have concluded that the distinction between these costs is actually an accounting artifact and that, in fact, to restate the epiphany, the teaching hospitals offset those reported direct costs of residency programs by paying residents to provide care than what they would have to pay them if they were not also providing them with training. So this means both the direct and the indirect costs reflect patient care costs.

I'm just restating this, since the audience came in halfway through on the discussion of this.

That's what Medicare is buying, patient care costs. What should Medicare be buying? And this is the topic of the recommendations, but I think two things. One, patient care services for Medicare beneficiaries. Second, we want to preserve access to the enhanced patient care that's provided in teaching hospitals and perhaps other teaching settings.

The issue of how the program should pay for what it buys, I think there does need to be a two-part discussion of this. One is is the conceptual framework that we've tried to lay out in the document that we've given you, and in fact what we've talked about in our March report, that Medicare in its pricing mechanism should try and approximate efficient provider's costs and try to match its payments to those expected efficient costs better.

In there's a recommendation, you'll get to them, there's a suggestion that suggests pooling of what's currently a direct med-ed and an indirect med-ed adjustment, but there is obviously a big step between the conceptual notion of doing that and the empirical notion. What we are trying to bring you today is just a set of draft recommendations that lay out that conceptual framework to

guide refinement of Medicare's payments and we were happy to include discussion of the future work which, as we've mentioned, would be appropriate for our March report and perhaps beyond that.

I just wanted to -- I feel like I'm coming in a little bit late, but I wanted to review the bidding briefly on where we are and recognize that while the audience sees a draft summary and a list of recommendations. They may not recall all of the months of discussion that have led up to this. So I'll just stop there.

DR. ROWE: Thank you, Murray. I'd like to address two issues which I think should be in the documentation some level. One is referred to in one sentence, and Gail referred to it in her introductory comments, and that is the issue of transition. That was one of the things you thought we should discuss.

There is a history in the Medicare program of transition. The most recent, I think, was with respect to the Medicare+Choice programs, it was a two-year transition I think, Berenson's rule, five year transition. There was the capital payments that Gail referred to, which was a 10-year transition about which, now that it's getting into year

eight or nine or whatever, people are beginning to think that 10 years was too short.

I think the amount of money that could potentially be moved around here is very significant. For at least the hospitals that I know best, it's four times the capital. So I think that it would be worth having a paragraph in here to flesh out a little bit. Just leaving saying we recommend a transition is, I think, a little too cute. I think we need to be a little more specific because people can interpret that any way they want, and some people will interpret it very different than others and use that statement as support for their interpretation.

So I think we have to be a little less conceptual with respect to that and give a little history and say there are these varying things and this is how much money is on the table. And we will do models and we will do simulations and we will then come back with a specific recommendation about how long. I guess that would be the idea.

So that would be my recommendation with respect to transition. I don't think we, at this point, should come up with a recommendation of how long because I don't think we've seen the numbers and we don't really know. So that

wouldn't be fair, either.

DR. WILENSKY: I think it might be if we were -- let me just continue with that thought, there have been some different philosophies in the sense of whether or not you put a limit on the amount of dollar loss that occurs and with the RBRVS, had that or a percentage change, and the differing amounts of time, which I think have gone from two to 10 years.

DR. ROWE: I think we could throw all of that in some paragraph and say that will be one of the specific tasks that the commission will address and come up with some specific recommendations, or at least some options for Congress.

The other issue, which I didn't see in the report, but since I said transition wasn't in there and I was corrected, I'm not going to say it's not there. I'll just say I don't remember seeing it, was how to deal with Medicare+Choice.

As you all are aware, there was a lot of discussion about carving out the medical education payments from the Medicare+Choice payments to the plans, so that those payments would be given directly to hospitals, and

transitioning that over X years.

If we are saying that these payments are really payments for services, then there are going to be two clear interpretations. The hospitals are going to say well, those payments should be provided to the people who provide those services, and therefore it should go to the hospitals. And if you give it to the plans we'll never see it. Or your intent that it goes to the hospital is subject to a negotiation by another party.

And the plans will say we're contracting to provide payments for all the services to these people and now you've defined these payments as services, and therefore it should go into the plan payment. I mean, this is very predictable and quite, in fact, reasonable.

My understanding is that this document is silent with respect to that issue. I think that if we are expecting that Medicare+Choice will be, notwithstanding recent changes in the last six months of going sideways, will be a very important part of the Medicare program in the future. I think we should have a discussion about this. We should address it. There should be some statement in this report with respect to that, because this could be a make or

break issue with respect to some of these concepts in terms of how they get actuated.

So I think is something we should discuss.

DR. WILENSKY: Let me ask you, if there, as one could imagine, there's some split of interest in a panel of this nature, one way we could deal with it is saying here is where we're at now with the money, to the extent that you need to have increased payments go. In some ways, the current strategy recognizes the sense of what we are trying to say, which is it is more expensive to go to these institutions. If there isn't money set aside to allow that to happen they won't, in fact, be able to be used.

There may be some debate about whether it was necessary to do this. But the fact is, it is consistent.

If there is an agreement or a consensus among the commissioners about stay with the strategy that has been put in place, which is put it aside and use it as its used, as opposed to going back to how we used to do it, we are certainly able to come to that. I had assumed that might be an area in which we might not have agreement, and therefore being silent was consistent with the current practice. But we can certainly take that out.

DR. ROWE: That might be fine, too. But at least I think it's worth raising it in the commission for discussion. We may decide to leave it out of the document because of the inherent disagreement.

DR. LEWERS: I was going to try to take us back to where our charge began in the BBA. I think Murray did a great job of summarizing that much more eloquently than I could. I generally agree with most of the statements, except Gerry's last statement, and he's not here to listen to that.

I hear a consensus that this is almost a work in progress, we've not had time to complete, et cetera, et cetera. I agree with that.

But at one point, we had a set of principles that we were dealing with and had discussed, and I think we've left those. They're not here, at least not spelled out.

For instance, on the first page of our report, we immediately get into the Newhouse theory of payment. But the first principle is on the top of page two, which I think is a critical one. I think we need to go back and put some basis on that, for the audience, that says the commission believes that the value of this enhanced patient care to

Medicare beneficiaries exceeds the cost of providing it, making it appropriate for Medicare to recognize such costs in the patient care payments the program makes to teaching hospitals.

I think that's a basic principle. I think Congress wants to hear us say yes, the Medicare program should pay for teaching. We're saying it but we've buried it into the body. I would like us to go back and consider the principles that we had. I believe it was at the retreat, and I don't know whether they were presented in the public session, since I wasn't here.

But I think we should start this whole process with some very basic principles of what we firmly believe and then get back into developing how we're going to get there to develop, or at least to address those principles. I think we've lost that in leaving those principles out of here.

DR. WILENSKY: Let me just clarify though. The principle as I recall it was not so much that Medicare ought to pay for teaching, but that there is something, a better quality that occurs in institutions that are engaged in training, and we want to make sure that seniors have access

to those institutions. Since they cost more, it implies an enhanced payment.

Now that may sound like I'm being picky or petty, but the fact is if we are going to try to get a change in thinking about it, we have to ban this concept that we're literally paying for teaching. We're paying for access to enhanced quality of care, which we believe is occurring in these institutions, as we discussed at the retreat and elsewhere in public, that there are a whole set of activities that go on in these institutions and is in here in terms of access to technology at a newer time, the state of the art use of new procedures and techniques and devices.

It is associated with the institutions that are also engaged in teaching and that all of those activities are resulting in increased costs which, if you don't have enhanced payment for, will mean our seniors cannot access.

So we need to focus on it. But having said that, I agree that we may want to go back one around to see whether or not we're having some difficulty in deciding what to call those things that we were looking at.

DR. LEWERS: Yes, basic premise. I don't care what you call it, Gail, but you're saying the exact same

thing. That is one of the very basic points that we made very early on and yet it's here but you've really got to read and interpret to get it. And I think we need to put that up front, let Congress know, these are the basic issues we're thinking about.

And yes, there needs to be change. But we want to change something because we want to make it realistic.

MR. JOHNSON: One comment, going back to something Hugh said, and then I have a question of Joe and Murray on purpose.

The other thing about whether this is a recommendation versus a conceptual thing, we have to also remember there are other programs that look at what Medicare does; i.e., state Medicaid programs, that pay teaching costs and DSH costs. And people like Blue Cross-Blue Shield who pay teaching costs.

So I just want to make the point, whether this is conceptual or recommendations could generate beyond just Medicare.

The other question I have is on our purpose. Murray very well pointed out that our purpose was to have access to enhanced care in teaching hospitals for this

population. We've certainly talked about that. But this sort of reminds me of the intellectual integrity of the idea of we don't look at hospital margins when we do the update. That's a separate compartment.

And I see a separate compartment coming up here, and that is the fact that Joe also said how we pay will affect how teaching hospitals behave as to the number and type of residents. And so while we keep talking about this enhanced payment, and that this is sort of just a commodity money issue for this enhanced service, the fact is we keep looping back, either by what Jack said, and Judy, about training the right kind of people for this population or maybe not training as many people if we average out the payment because those who are training a lot at a high cost, they'll jettison those.

I'm just having trouble recognizing in our purpose that we're only tinkering in an economic sense with this financial model versus we're implicitly making manpower policy when we say somebody else should be doing that, in terms of the number and types of residents.

So that's an observation and I'm just having a problem reconciling that in our purpose.

DR. NEWHOUSE: I think that's certainly a fair question. I would have said it's really a historical accident that Medicare got into this business, because I think the original intent, although Julian was present at the creation and can speak to it, was that Medicare be neutral on this score. I don't think Medicare set out with the notion that it wanted to subsidize residents.

But when Julian ran his regression back in '81, he found that the number of residents per bed was a very good proxy for costliness of the hospital's cost per case. And it came into the regression as an explanatory variable and people said this correlates pretty well with teaching intensity and why don't we pay on it.

But once we started to pay on it, then hospitals changed their behavior. But I don't think at the time that PPS went in that anybody had the intent that we were deliberately trying to subsidize residents. We were subsidizing hospitals to add residents, let me put it that way. This happened by historical accident.

Later I'll come back to Jack's issue on Medicare+Choice.

DR. WILENSKY: But presumably we could, when we do

these empirical analyses, maybe we might be so lucky as to find there is something --

DR. ROWE: Another variable.

DR. WILENSKY: That doesn't have the same kind of implications.

DR. NEWHOUSE: So it would be more neutral.

DR. WILENSKY: Exactly. I mean, this is a problem, that although we're not intending to do this, we are doing it and therefore, if we could find, if we could approximate a correlate to the increased costs that had fewer unintended consequences, it would certainly be desirable.

DR. LAVE: I really want to come back to an issue that Peter raised because I think that it's critical. That is that I think correctly most of our discussion has focused on payment policies and payments for inpatient care. The draft report does look as the implications of this maybe for revising payments for exempt units.

I do think that we have to think about, in terms of this framework, what it means for other payers and for other types of services, particular services in outpatient departments, clinics and so forth.

I guess one of the things that I wonder, as we think about this, is whether or not there are any rules that affect the way we pay for services provided in those settings, both the services to the physicians as well as the services to the facilities, that in fact may have negative implications with respect to whether or not they could be a training site.

Now this is not to say that I want to pay for training sites. But if in fact we have a set of payment policies that basically mean it's financially impossible to train people in that site, then I think maybe not here but we ought to raise it.

For instance, if I think about a lawyer and they're training associates, if you said you could make some statements that would say the way we pay for legal services would make it impossible to have associates in those settings if you wouldn't let them bill. I don't know what the appropriate transfer is, but one of the things, in fact, that there is a concern about is whether or not, in fact, the payment system discourages training in the most appropriate setting.

Now I'm not saying that we want to say you have to

train in these settings, but I do think that when we establish a framework for providing for patient care services in different settings, that in fact we would not want to make them discourage the training in that particular setting.

So that this is not an issue when we're talking about payments for hospital services. It may be an issue when you move to different types of facilities.

DR. ROWE: I think for example -- and I'm not proposing this, but just to give a specific example, long-term care settings, nursing home settings. I mean, there is no training in nursing homes of residents, to my knowledge it's not compensated for. Well, this is Medicare beneficiaries, we want them to get care. It would be nice if their doctors knew how to take care of the patients who lived in nursing homes, or in home care.

It's not just the outpatient department that's the other setting. There are these other settings.

DR. LAVE: So I'm not suggesting that we solve that problem, but I do think if we have an implication that says we are not paying for training, we want to make sure that our payment policy does not per se discourage training

in that setting. It should be neutral.

MS. NEWPORT: I guess I normally don't speak to this issue but feel compelled, and given the importance of this report, to align myself with the basic notion that has been reiterated several times, we've used concept, we've used recommendation, we've used first principles and assumptions and Joe's epiphany.

I think the framework of the paper has to set that out very clearly and I think, in order for folks who don't deal with this issue all the time, and maybe folks on the Hill, that will have to therefore take their thinking in a new direction and that will require certain very specific actions on their part. That if the basic assumption is that we've set out is true and the change we're recommending, in terms of a different type of compensation for this is the right way to go, then that has to therefore lead to actions that will have to be specific to the consequences of that, including payment transfers.

What do we need to do in terms of the right payment for these services and placing the right value on those services? So I have no disagreement with the basic thoughts that have been put out, in terms of concerns about

framing this the right way.

Now in that context, and my friend Jack has rightly raised what are we going to do about Medicare+Choice payments. My suggestion would be that acknowledge of that, as an ongoing issue, and something that is worth further consideration in alignment with all the other things that will be driven by this change in payment, there needs to be I would say place savers for that, as well as other things.

I don't want the notion to be furthered at this point, at the beginning of the next stage, to use Murray's example, that there is somehow conflict that will automatically exist that is any different than the conflicts that will automatically exist in any of these other areas. Further thought needs to be taken.

I would just say that if we reserve, as we have in these other areas, the notion that this needs further study and further connection, then I would be very comfortable with that. And I think that's really where I'm going, is that this is a process. I think it's critical that the commission set this up contextually in the right way so that the debate then will go to the next level and that we can support that and hope that the end result will be a much

more balanced payment system that recognizes the value of these services.

So I just want to step in and say that. I think that I'm very comfortable with folks concerns, but I think we are talking about crafting this just slightly different to make the right emphasis, and I concur with the need to do that.

DR. LONG: I think it was Bill who mentioned earlier the need to provide some emphasis or explication of the formula that's in the paper, which at least the version I'm looking at is on page five. But it's referred to in a couple of other places.

I have a concern that I think it may not fully reflect the current situation in contrast, again, to where we want to go and the conceptual notion that in the current world I'm not certain that we are dealing purely with accounting artifacts here.

Far be it from me to defend the accounting world, but I think probably we can find at least some instances where teaching hospitals, in fact, may make their decisions on things like, for example, resident salary with an eye to direct medical education payments, regardless of how the

accounting produces those payments. And that, in fact, that the wages paid to residents certainly should reflect the value of the services that they produce minus the costs of training.

But it is conceivable that there is a positive into that equation in the sense that the cost of training is reduced to the extent that there is a payment that's explicit and tied to those costs of training coming from Medicare or anyone else, for that matter.

So I think, although ideally where we might like to be and where I think we ought to go, is to have the equation be that the costs of training, the combination of salaries for the residents plus the other costs of running the program, together should be less than or equal to the value of the services provided. That currently it may well be that that is not the complete equation for at least some residency settings.

MR. MacBAIN: A couple things. One, just to respond to Hugh's comments. I agree. One of my concerns is that, for some hospitals, Medicare payment policies over the last whatever it is, 15 years, may have distorted what otherwise would work. The theory may not match the numbers

because Medicare has messed with the numbers. We ought to get some sense of that. So I agree with your point, and it just underscores the reason why I was asking for some sort of empirical verification.

Although, I think Joe is making the point, too, that if the theory is right then you would expect that, as Medicare enhances the economic value to the hospital, that you would either see more residency programs or higher salaries or both, and I think that's what we're seeing. So it doesn't invalidate the theory. It just complicates the transition.

The other comment was just to underscore what Gail was saying about the references about the number of residents or resident intensity. I think including that in this report really weakens our argument. There are several places, I think, on one page in here where we talked about still assuming that payment rates from individual hospital would be adjusted by the number of residents.

And I'm not sure we want to talk about that. It's a little too specific for a framework issue anyway, but it weakens the argument that if the residents are ultimately bearing the cost of their training, then the number of

residents, adding one more resident shouldn't add any cost.

DR. WILENSKY: Especially if we can preferably find a different correlate, to just get rid of that.

MR. MacBAIN: I also didn't realize that Julian was responsible for this troublesome regression that's caused all this trouble.

DR. NEWHOUSE: It may be better than any alternative.

Let me start out with this last point of Hugh and Bill. Technically, the answer to this depends on the elasticity of the supply curve of residents, which means as you add residents do you have to bid up the price to get many more? Another way to say that is how far above the salary with just USMGs would you have to go to keep adding more IMGs?

So the answer is that the adjustment is going to be on both --

DR. WILENSKY: Say the last part again.

DR. NEWHOUSE: Since the additional supply is going to have to come from abroad, will you get all the residents you want to hire, given the size of the subsidy, at the initial prevailing American wages? The answer

empirically, since I don't think a whole lot has happened to salaries because it just seems to be yes, that we've been able to recruit from abroad at the prevailing rate. You haven't had to raise the wages to get more.

First, a comment on the Medicare+Choice rates. We really haven't discussed this and I've been trying to think about it, and here's the best I can do in terms of analyzing this issue. I started, although I'll back off this at the end, but I started with competitive markets for both hospitals and health plans, because that's the simplest case.

Now in that case, it seems to me to reduce to a consumer sovereignty issue in the following way, that the current strategy is that you give the dollars to the teaching hospitals so if the market is competitive, in effect, they would lower their rates to health plans, it would be a level playing field across teaching and non-teaching hospitals, and it would be equally attractive to go to teaching hospitals.

The alternative strategy is to leave the money with the plans and then if the plans want to pay the cost of teaching hospitals, they pay the cost of teaching hospitals.

If that market is competitive, then plans that use teaching hospitals more are going to have higher premiums and conversely.

And then we get back to what do the beneficiaries choose when faced with higher premiums from plans that use teaching hospitals more. Which is why I say it resolves to a consumer sovereignty issue. Do you want to say people don't really know what they're doing on this particular aspect of it when they elect their plan. They don't foresee that they may want to be in a teaching hospital and they elect a plan that doesn't use teaching hospitals much because it's cheap.

But we don't really want to give them that choice, so we'll just give it to the teaching hospital, let that field be level in terms of the choice the plan makes. Or yes, people should be able to elect cheap rates to somewhat abridge their ability to go to teaching hospitals.

If you back off the competition, if there's not competition in the hospital market and you give it to hospitals, the hospitals can just potentially pocket the money and use it for other purposes or whatever. And if you give the plans the money, obviously they can pocket the

money if the plan market isn't competitive.

So that's as far as I've gotten in thinking about that issue, but I think I agree with Gail that maybe the most -- I mean, if people agree with this analysis or if it stands up on reflection, that the furthest I could see going is trying to lay out the issue. If we want to get to a recommendation, we could.

DR. WILENSKY: I don't think that we're going to get to a recommendation on that issue. Not now.

DR. NEWHOUSE: Not today. Let me say a word about other settings, too.

DR. ROWE: Since both the representatives, the major representatives of the plans, are out of the room, I'd like to call for a vote on this recommendation.

[Laughter.]

DR. ROWE: And I think there's a phone call for you, Joe.

[Laughter.]

DR. NEWHOUSE: You might be surprised.

DR. ROWE: I might, but I'm not willing to take the chance.

DR. NEWHOUSE: I see, you're risk averter.

DR. ROWE: Because the last close call went the other way.

DR. NEWHOUSE: In other settings, at one level I think this is easy. At another level, I think it's terribly difficult. The easy part is that I think kind of the general notion that are we getting a different product, and if so is the product more expensive? And if so, is it worth the difference in costs? I think that all applies in the other settings.

The difficulty is trying to measure the different products. This in a way goes back to what I was saying to Carol. We've kind of more or less bought the assumption but this has to be a judgment on our part, that the different product on the inpatient side is correlated with the number of residents. The residents are counted per bed as a proxy for that.

DR. WILENSKY: Is that --

DR. NEWHOUSE: It may not be. It's just a judgment. Given the current formula, that's the way we do it. Maybe we can improve the formula, but that's a judgment.

It may be that on the outpatient side, for

example, that there is a different product. We've had some discussion in that. It may be that the different product there doesn't correlate so well in a judgment with the number of residents, or maybe it does.

DR. WILENSKY: I'm not sure that the --

DR. NEWHOUSE: I don't know. Since we can't measure the product, there's no way to prove or disprove it it's just kind of a judgment call.

DR. WILENSKY: Let me go back and see if I understood your statement. It's one thing to say that there is a strong correlation between teaching intensity and cost. And since we want to have access to this higher cost, better quality product, that means that we may have to pay more. And if the number of residents is a good correlate, that's not a bad way to have as part of the payment formula.

But it's not obvious to me that saying that this higher quality is correlated with the number of residents.

DR. NEWHOUSE: You mean anywhere?

DR. WILENSKY: No, just in general.

DR. NEWHOUSE: It seems to me we are making that statement. The higher cost we can demonstrate empirically. We're making a judgment, at least on the inpatient side,

that since we're paying more to hospitals that have more residents that we're getting back more value than what it's costing us.

DR. WILENSKY: I know, but it strikes me right now that if what we are saying is what we are trying to do is to adopt a framework or our recommendation is to adopt a framework where we pay an enhanced payment for institutions that have higher costs in part because they are engaged in training, which we believe provides a quality product that we don't want to shut off for our seniors, that whether or not we end up in the future paying per resident or some other enhanced payment definition is something that we ought to leave for the empirical --

DR. NEWHOUSE: I think we could be stronger we'd rather not pay per resident, since that distorts decisions.

DR. WILENSKY: We can definitely say we would prefer not to do this, since it distorts it. And whether or not we can come up with an alternative definition that will provide additional monies that is not based on per resident but based on some other correlate, is that will be a part of the next report.

DR. NEWHOUSE: Do you think we're going to get

there for other settings?

DR. WILENSKY: That's a different issue.

DR. NEWHOUSE: I think that is Peter's question. I don't know how to get there from here. But I don't know that we --

DR. WILENSKY: But that doesn't stop us from saying that for the inpatient where --

DR. NEWHOUSE: Or the framework.

DR. WILENSKY: It certainly doesn't stop from the framework, but it also doesn't stop from saying that when we're at a position to make a recommendation of how we think payments ought to be made on the inpatient level, that it will be based on an empirical analysis of what is correlated with these increased costs and certainly indicate that our preference is that it not be related to the number of residents because that's had consequences that were not intended at the time it was introduced, and we would hope to not carry into the future.

DR. KEMPER: Right, but to the extent that care is moving out of the inpatient setting, and training presumably should follow, just to get down to nuts and bolts, what regression is going to be run?

DR. NEWHOUSE: In the nuts and bolts, it's what are the accounting rules for how you count residents?

DR. KEMPER: Right. But also what happens when they are outside the hospital system --

DR. NEWHOUSE: That's what I mean. You count the time outside the hospital.

DR. KEMPER: But even outside the hospital system, even outside the outpatient department that's in any community setting, how do you deal with that?

And what about other proffessions? How do you make the judgment whether there is enhanced patient care or not? We'll sort of say gee, in the inpatient setting that's enhanced patient care, we can accept that exceeds the costs, but where does this framework take us with respect to the other settings and the other professions?

That's what I don't see what the framework says. It's nice to put down the framework, but where does it go?

MR. MacBAIN: Just on the same issue, the regression, as I recall, is not only a function of residents but of beds. I think what we're talking about is wanting some sort of methodology that frees us from dependence on both residents and beds. So we really need to find

something, whether it's an intensity adjusted case mix index or something along those lines, that gets to the characteristics of the patients or the services being provided, is much closer to the theoretical basis for our recommendation.

DR. WILENSKY: But I think, at this point, it is our preference to find such a measure. Whether or not there will be such a measure, I mean, at worse we'll be back on that aspect to where we are now. And we will attempt to find a correlate for payment purposes that has fewer negative consequences.

DR. ROWE: The test would be we need something that explains at least as much, if not more, variance with respect to these issues than the current one. If it doesn't do it better than the current one, even though we have these adverse incentives and other things that we have to put caps on the number of residents, is still not reason to throw it out, right?

DR. NEWHOUSE: There's tricky business. On the assumption that all of the costs that the institutions are writing down are something we want to pay for, yes, then it follows that we should want to explain variance that are

associated with some products --

DR. ROWE: I understand, but that was what was done in 1984 by Julian.

DR. LAVE: They pulled the direct costs out. What we're doing now is talking --

DR. NEWHOUSE: But that wouldn't have much affected, I think, the results.

DR. LAVE: But remember, there were large numbers of institutions who didn't pay very much for their direct costs.

MR. MacBAIN: The original regression was run on data based on a system that was cost reimbursed. Now we've got 15 years worth of distortions introduced into the number of residents because there's been an incentive to add more residents. So any regression based on that distorted data now is going to be subject to question, at least in my mind.

DR. NEWHOUSE: Except that in principle it's there's anyway, because the direct medical education payments are proportional to number of residents.

MR. MacBAIN: But the indirect --

DR. NEWHOUSE: Indirect are, too.

MR. MacBAIN: But now the number of residents is

the scorer.

DR. NEWHOUSE: Yes. So the regression -- well, that's right. That still doesn't necessarily affect it.

DR. KEMPER: The notion of taking residents out of the equation, the only concern I have about that is, there's also the requirement that the services be valued. And so, the least efficient hospitals are the ones that have the highest cost, therefore we should pay more for that. I think that if there's some other proxy, maybe scale or whatever, we don't want to pay on it.

So I think you really need to have something related to the medical education in order to say there was this valued service that we want to pay more for.

DR. NEWHOUSE: No, I think you want something related to the product. You don't have it.

DR. WILENSKY: But again, this is not particularly good use of our time now. The point that we want to make, I think, at this point, is that we have been paying on the basis of number of residents. We recognize that has had undesirable, unintended consequences. When we are estimating the relationship between the cost associated to make enhanced payment payments, if we can find other

measures or if we can -- we will now go and explicitly, and I don't know how much it was explicitly understood what would be the implications of adopting the kind of payment system, but however much thought was given previously. We clearly have now 15 years worth of experience, reminding us how much we need to keep in mind unintended consequences of the unit of payment.

If we find a different one, we'll probably discover other unintended consequences, but at least we will try to explore, and I think that's the kind of message that we would want to have in this report, is that as part of the empirical work we will see whether or not we can avoid the known pitfalls that we're now in, probably come up with other pitfalls to be discovered in the next decade after.

Julian?

MR. PETTENGILL:

If you have any suggestions, you know my e-mail address.

[Laughter.]

DR. LAVE: I have a question that's actually related to the whole series of suggested changes, that maybe we'll want to come to it later. But we basically, and I

think correctly, have tied our recommendation in with a recommended change in the product definition at the same time. I think we've tied those things together.

And as I think about other settings, I think to think about the product definition probably may get us some of the way there as well, what it is we pay for. We talked about geriatric assessment. It doesn't make much difference.

But do we want to have any sort of thoughts about whether or not, in fact, we would be willing to think of -- even in terms of this framework, we have to tie the discussion with the products that we're paying for. In the inpatient side there is a new class of products that are out there, that we could pay for, the ADRGs and the APDRGs or whatever we're going to work with.

I think that one of the things that we may want to think about is whether or not, in fact, we think that the two have to go together in terms of the next steps? Or is that the next report? Because I think it's very important to tie it all together.

Because it's going to make a big difference to the size of the coefficient. It's going to make a big

difference to the recommended size I think.

DR. KEMPER: When you say ADRGs, you mean the --

DR. LAVE: I mean, there is another patient classification system which basically is a more refined patient classification system. And as a case mix classification system it accounts for more of the variation in costs per case.

It also has the implication of reducing the estimated coefficient of the IRB, which showed that the interns and residents per bed are, to some extent, standing as a surrogate for case mix differences and case mix complexity across these particular institutions.

And since our goal is really to pay for products rather than to pay for teaching, and I think as we think about all of the different settings, we keep thinking about products rather than teaching, and making sure that we have a way of paying for those products, maybe regardless of who is providing them, I think we get some of the way there.

So I see the two as being linked.

DR. WILENSKY: Yes, they are definitely linked.

DR. LAVE: We're really talking about where, even in a conceptual framework. And that's why I believe that at

the beginning we have to have a discussion about the whole product training interface to expand what we have in here.

DR. WILENSKY: I just want to make sure everybody, all the commissioners, have recognized it was in this report that one of the areas that we are recommending is that we explore the use of a more differentiated medical classification system that would allow us to pay directly for some of the patient severity mixes that we may be paying indirectly with some of our medical education payments, and that it would reduce the need to rely on these proxy measures if we could come up with a better differentiated classification system.

DR. NEWHOUSE: And reduce the distortion.

DR. WILENSKY: And reduce the distortion.

DR. ROSS: If I could just make one point, from the discussion I'm hearing, we'd like to have everything at the beginning. As a practical matter, we can't do that.

But I wonder if it's useful to start turning to some of what we've laid out as draft recommendations. We can discuss semantics as we go along with our principal recommendations or premises, the things that will be in bold face, because most of the things I've heard the

commissioners talking about, as Gail just mentioned on the point for the refined DRGs and other kinds of sort of calculation precision adjustments.

I think we have covered most of them in the text somewhere. The question is where things need more explanation or more emphasis or more clarity. And that's where we can use feedback. But most of the things that have come up in the first hour-and-a-half or two hours of discussion here, I believe are already in the document.

So clearly we need to highlight certain things or give a little bit more emphasis where the language is pretty dense at this point.

DR. WILENSKY: I think what I would translate or what I would summarize the bottom line of this morning's discussion, is that the context in which the principles or recommendations are occurring needs to be fleshed out. It's that context of what it is we're trying to accomplish and why we're going in this direction, as opposed to where we have been in the past with regard to GME payments is probably the most critical thing.

The order in which you present these ideas, because we are fundamentally asking people to rethink how

they think about this issue is very important. This is also an important issue, but it's particularly so now, because we're asking people to think about things differently. And therefore, having something come later becomes much more serious than if it is just a refinement of the last two or three or four years of working.

So I don't disagree with you. I think that most of the issues that we've raised this morning actually are in the document but they come page two or page seven or whatever, and it's going to be very important that we get what needs to be up front up front.

Peter, and then I would like to go to some of these draft recommendations. I am assuming that we have gotten over, although we've come back into this notion of yes, we can have as a recommendation a framework of how to think about something.

DR. KEMPER: I guess on this whole package issue of revising the DRGs, that seems to me very important that it be a package and that that get more emphasis.

I guess one of the questions that I've had about this, and I guess I don't know who -- maybe Joe, you're the one to address it to. But within this framework, who is it

that ought to get these enhanced services? That is to say, they're now enhanced services and I guess that means implicitly some other kind of service.

At one level you don't want somebody with an infected hangnail going to the national academic center for hand surgery to get it treated. If you thought about a health plan, a health plan might contract with academic medical centers and other hospitals and other outpatient departments and direct patients to the academic setting in the cases where it's appropriate.

How do we deal with that issue if you think about the enhanced product? And then how do people get directed?

DR. WILENSKY: We don't now and we haven't in terms of Medicare. My recommendation is since, other than in an emergency room, where you go depends on the health professional you see and his or her recommendation, that I don't see that this is something that we would want to get into. Unless there's some interest on the part of commissioners to try to be directive in this manner, I can't imagine why we want to get into it.

We don't do it now. People go to settings according to the physicians or other health care workers

that they see.

DR. KEMPER: That's true. We make a big deal about efficiency in production in this document. We don't really talk about efficiency in appropriateness of use of the academic medical centers.

DR. NEWHOUSE: I think that goes to the Medicare+Choice issue. I mean, within the traditional -- this document is really within the traditional plan.

DR. WILENSKY: Because you are buying a package and a direction.

DR. NEWHOUSE: Let me comment on the enhanced DRG point that Judy and Peter raised, too. I think that issue does depend somewhat on how the numbers come out, because when we change the system we can be fairly sure we're going to pay a price in upcoding that will be an unintended price but we can be pretty sure we'll pay it. We know what happened when we abolished age in the DRG system.

And so I'd like to reserve some judgment there until I do see the numbers. How much variance is explained by increasing the number of DRGs? How much it knocks down the coefficient on interns and residents to bed before just saying we definitely should do it.

DR. WILENSKY: I would like to, if the group is comfortable doing that, to suggest that we look at the various recommendations which have been grouped into four categories. You have it as a summary statement, as well as what is in your broader paper.

MS. NEWPORT: Going back to what I was saying earlier, I think that this recommendation is more of our assumption and principle and they maybe need to be crafted to that it's kind of -- if you reframe the text a little differently, you may want to say this statement, not in terms of a recommendation, but an assumption, a concept, whatever. Then therefore, Congress will need to do -- and that comes where your recommendations are.

When I read this, that's what seemed to be the context. So it's not that I disagree with this notionally. I just think that, in terms of putting this forward, that we're restating the basic change in concept that we're recommending and then, therefore, these actions will have to occur.

So offer up for your thought and further discussion, but that just sort of worked for me when I was thinking about this.

MS. ROSENBLATT: The first sentence here was bothering me last time we met and it's continued to bother me as I read the material. Even though the words value and raise cost are together, and I know the logical definition of the word and, and the word and is underlined, I still have a problem with the raise costs. And unfortunately, I was hoping Jack could give me some help on the vocabulary here.

But I'm going to give a suggestion which is not intended -- I don't think it's perfect wording but it's more of an idea. But I think if we could say and lead to justifiable increased costs or something that denotes something like that, it might read a little bit better.

MR. MacBAIN: The recommendation deals with all patient care payments, which implies across settings. In the summary we talk more specifically about a single adjustment to DRG payments, which I think is at variance with what we're really trying to do. So I'm not so uncomfortable with the recommendation as I am with how its finding its way into the summary, for those who don't read past that.

That kind of -- there's that tension all the way

through this report. Are we really just talking about DRGs or across broader settings? So in redrafting this, I'd just like to stress that we really should keep it general. The issue here is some sort of recognition in all of those settings where the additional cost is justified by the additional value.

MR. JOHNSON: Going down to recommendation three, I applaud whoever did it for putting the Boren amendment back on the table, I'm looking forward to that. But based on going back to what Alice said about the raise costs or justifiable cost, and then you go down and talk about an efficient provider's cost of care, and then we talk about the regional variation, whether it's wages or the cost basis of the hospital or whatever else.

A lot of this, while intuitively sensible, is probably practically contradictory. And I don't know how we weave that together, in terms of various adjustments.

DR. LAVE: I like Alice's change in one. I didn't like value and raise cost. I kept trying to think of alternative ways of doing that. I basically then did not like the therefore should consider direct expenses. To me, there's no logical connection between the first part of the

sentence and the second part of the sentence.

So it seems to me that they should be separate as part of the framework in determining that one of the aspects that may raise value is the presence of graduate medical education. But to me there is no connection between part one and part two of that recommendation.

I think that the payments should reflect product differences that are a value, and that have justifiably higher costs, it may be that the commission believes that teaching hospitals have justifiably higher costs and therefore these should be paid. Or something like that, but these two statements don't follow.

DR. WILENSKY: Joe, did you have a comment?

DR. NEWHOUSE: Yes. This doesn't solve that last problem, but let me try to help with Alice's problem.

The first sentence could read Medicare payments should reflect product differences whose value justifies their increased costs.

MS. ROSENBLATT: Would you read that again, Joe?

DR. LAVE: I like that.

DR. NEWHOUSE: It's the same first six words up to that, and then after product differences, whose value

justifies their increased costs.

MR. MacBAIN: In the second sentence it sounds like we're saying let's take the two components and squish them together. Are we really saying let's recalculate what we should be paying for these services, based on the enhanced DRG system and whatever we do with outpatient and other services?

DR. WILENSKY: That is certainly going to be the -- I think that is --

MR. MacBAIN: So maybe we don't want to make reference to the term direct graduate medical education in the recommendation, but just talk about the unique costs of providing higher value services and teaching hospitals.

MS. RAPHAEL: Why can't you go from the first sentence in one to two?

DR. WILENSKY: Right.

DR. NEWHOUSE: That's fine.

DR. LAVE: I think that maybe we want to have a recommendation that says that the Congress should not pay directly for the direct costs of graduate medical education, and basically say we want to get rid of that. And then come back and make the next one, because I think again, if we

have this different framework for thinking about things, and we have this paradigm shift, the first thing in the paradigm shift is that we're not going to pay directly for the direct cost of graduate medical education. And I think that that's what we're saying, that it has to be explicitly a recommendation.

And then we go to two, we cross off three, the second part of one and then follow Carol's recommendation that it should recommended through an enhanced patient adjustment. I would have period, and then say it is likely that, in calculating the enhanced patient adjustment, that there should be something that says that this is going to be part of our calculation process of doing it, rather than a that. So we may want to put a period and then another -- this can be done in some way.

DR. WAKEFIELD: Apologies if this question has already been raised. You can tell me, and then Murray can tell me on the side what the response was.

With regard to this recommendation, using those two criteria of increased value and increased costs, do you have any sense about how those might be applied to, number one, non-physician providers in hospitals? Nurses, for

example. And the added value associated with training, if that can be quantified. And how might those criteria be applied to those providers whose training isn't currently reimbursed, but who are trained in hospitals, for example, such as clinical psychologists?

So how might those criteria be applied to other health care providers? Have we thought about that in inpatient?

DR. WILENSKY: But make sure you understand what it is we would be doing. We're not talking about paying for direct education for any of these people, nor would we.

DR. WAKEFIELD: Right, patient care.

DR. WILENSKY: It's only a question of where the training of those individuals are different and adds cost.

DR. WAKEFIELD: Yes, and value. So I'm saying, how would this be applied if, for example -- and I don't have a clue so I'm just going to put it out hypothetically.

If for example, clinical psychologists could say, and the hospitals where they were being trained, could say it costs us more to educate this provider group and here's the empirical data that shows that they've added value to Medicare beneficiaries' quality of care, that they received

better care.

How might, if they came to the table with that information, how would that be viewed given this recommendation and the way it's stated?

DR. WILENSKY: I guess one of the questions would be, are we not already picking up the increased costs in those institutions? And that would be an empirical question to try to answer whether they're unique institutions, as opposed to the ones that are also doing these other training. And whether the additional costs are either large enough to be measurable and measured and accounted for in some way.

Because again, we're not paying for the training. We're just paying for the fact that there are higher costs in institutions that are producing a value product we want to pay for, and that is not otherwise going to be compensated unless there's some enhanced payment cost?

So I think that would be the question, to my mind, whether or not you have something that's likely to be able to be picked up in some kind of measurable way?

My guess is that I don't know whether it would correlate with the institutions that are doing other

training highly, and that they're not -- even if it didn't, whether we'd be able to measure those kinds of variations.

DR. WAKEFIELD: And what that standard of proof is applied to those providers, as opposed to the value associated with training medical residents?

DR. NEWHOUSE: I'm still stuck on the first sentence in recommendation one. I thought it was clear, but maybe it isn't, that product differences we're talking about are inpatient care output, that we're not talking about education. So maybe we should say product differences in patient care or patient care product differences?

DR. WAKEFIELD: I apologize if I used education --

DR. NEWHOUSE: No, it just suddenly occurred to me.

DR. WAKEFIELD: Because I'm with you on the patient care. I understand that criterion. But I also see it being applied to non-physician providers potentially. So I wanted to see how, if this is the filter, those two concepts, how do other providers fit in that equation?

MR. MacBAIN: The issue may come down to allowable costs in determining what the costs of the hospital are and to what extent do the salaries of those people who are

engaged in teaching this whole range of non-physician professionals factor into calculating the cost? That's going to be a significant question. It's going to raise a host of issues in regard to those that are currently covered under direct medical education and those that are not.

DR. WILENSKY: Further comments on this first set of recommendations?

DR. NEWHOUSE: Are we now talking one through four?

DR. WILENSKY: We're now talking one through four?

MR. MacBAIN: To get back to Spencer's comment on three, does three add anything?

DR. NEWHOUSE: Isn't that current policy?

DR. WILENSKY: It is, as Murray reminded me, it's practically lifted verbatim from our March report.

MR. MacBAIN: Why don't we remove it? If we've already said it, why don't we remove it. It's not germane to this, except to the extent it's germane to all of Medicare.

MR. LISK: Let me just, to remind why that recommendation is there, and it may be because of how the wording has changed from what the commission's discussion

was at the last meeting. This is a recommendation that really justifies the improvements of the enhanced DRGs and those types of changes to improve payment policies so it does reflect these factors.

So it may be that you may want to more specifically state those things, rather than putting in these more general terms, that is in the principles of what was in the March report.

DR. WILENSKY: Then it strikes me -- either it needs to say something that isn't there or it should be out.

MR. LISK: So you need to decide which you prefer.

DR. WILENSKY: I think that if it adds something, and to the extent that we're talking about a refined classification system as producing a system of more appropriate payments that would include a more differentiated DRG system, that's fine.

DR. NEWHOUSE: Why don't we have some language about continuing to work on improving the formula for reimbursement? Maybe in the text, allude to that.

MS. RAPHAEL: Because I think what's confusing about that is the focus is on patient care product differentiation. And then all of a sudden, in the middle,

we're talking about efficient providers and reimbursing their costs of care. And it just doesn't hang together.

DR. NEWHOUSE: I just thought we were restating current policy.

DR. LAVE: It seems to me that when we talk about product differences whose value justifies their cost, their product differences can be within a DRG. It can be -- we could think about that very broadly. We could bring in Jack's a product could be the differentiation in terms of how say the -- differentiation in terms of how different products are produced, to go back to Jack's favorite since he did me a little favor a little bit ago.

Geriatric assessment could be a product differentiation whose additional value.

So it seems to me that's an extraordinarily generic kind of thing which says we want to focus on the product, we want to determine what makes products different.

MR. MacBAIN: Are we saying -- is the recommendation then to enhance the DRG system and find other intensity and severity measures that apply in other settings? Again, I don't want to just focus on DRGs.

DR. NEWHOUSE: I don't have the wording for it but

I'm comfortable with the recommendation.

MR. MacBAIN: The text talks about matching the DRG system. In my mind we're talking about a broader issue of intensity and severity across all settings where teaching is going on.

DR. WILENSKY: Right.

DR. NEWHOUSE: Just in response to Judy, of course, paying by the case, DRG system itself, through the case mix index, is reflecting product differences whose value we think justifies their cost.

DR. LAVE: That's right, but we want to start, it seems to me, with the product and --

DR. NEWHOUSE: And maybe the text should incorporate that thought, that current policy, in effect, tries to go in this direction.

DR. WILENSKY: We may want to take number four, even just in the recommendation and add another sentence with regard to the phase-in. I don't know whether people even in just the recommendation regard recommendation four as adequate with subsequent text explanation. Jack, this is an issue that you raised. Recommendation four, whether or not as a recommendation you're comfortable leaving the

statement as the header and then having a page of explanation as to the types of phase-ins that we could consider, or do you want to say something more in the recommendation?

DR. ROWE: No, I think I'd like to say two things. One is I would like to have some description of the issues relevant to phase-in, and the experiences. Then I would like a promissory note that MedPAC would undertake or is in the process of undertaking -- we have never really specifically asked the question of whether any analysis have been done, and if so, could we see them? But I'm assuming, based on the discussion, they haven't.

But MedPAC is in the process of conducting appropriate analyses to guide Congress' decision with respect to this. I think that's all we need. I think it's premature -- I can 20 years, 50 years, 10 years, four years, but I'm making it up. I mean, why don't we get some data? It might be the one area we would be outside of a data-free environment. In case you haven't noticed, this is a data-free environment.

[Laughter.]

DR. WILENSKY: Any further questions or comments

on this?

Any areas in which people would like --

DR. ROSS: Can we take a step back then just to make sure that staff have heard the changes you're proposing. So that under recommendation one it will read, Medicare payments should reflect product differences in patient care whose value justifies their higher costs. Then there is text explanation, but that second sentence does not appear there.

In recommendation number two, it will read that the Congress should recognize the higher value of patient care services provided in teaching hospitals through an enhanced patient care adjustment. This could mean incorporating direct GME costs into patient care payments.

I heard you saying you wanted to be less specific there?

DR. LAVE: No, I would do it very differently. In estimating this enhanced value one could -- I mean, you may want to do a period and include it in the text underneath about how one may go about doing this.

DR. WILENSKY: I actually think it's better to put it in the text because we don't know and we're not --

DR. LAVE: Yes, I don't like it in the recommendation. I think it should be in the text.

DR. NEWHOUSE: It think it should be in the text, but I think we could be stronger than "could", if we bought the whole thrust of the discussion.

DR. ROSS: That's what I'm asking.

DR. NEWHOUSE: I would be stronger than could. It would be should.

DR. WILENSKY: That is what we're -- when we do the reestimation, it is our intention --

DR. NEWHOUSE: That's what we would do.

DR. KEMPER: That's at the core of what we've been talking about.

DR. LAVE: But I think it should be a period. In reestimating --

DR. WILENSKY: No, we're not talking about having that be in the recommendation. We're talking about the first --

DR. NEWHOUSE: This is in the text.

DR. WILENSKY: This is in the text.

DR. LAVE: No, I think it should be in the text. Three goes.

DR. WILENSKY: Three is changed.

DR. ROSS: Three gets clarified to talk specifically about the kinds of refinements that one would do to do those estimates.

DR. NEWHOUSE: The kinds? Or just a generic discussion of refinement would seem to be all we'd want to say at this point.

DR. ROSS: Again, how generic? Is looking at refined DRGs a generic improvement or is that a specific?

DR. NEWHOUSE: That's generic. Refined, not otherwise specified.

MR. MacBAIN: Just generic DRGs is too narrow.

DR. NEWHOUSE: Yes, because we are going also into potentially reestimating the payment formula. So other technical improvements or something like that.

DR. ROSS: Those are reasonably specific to me.

DR. NEWHOUSE: Other technical improvements? That phrase by itself isn't specific.

MS. ROSENBLATT: I would like to see us maintain the word efficient in however we rework that sentence.

DR. NEWHOUSE: I think that recommendation one, in effect, covers the efficiency point. If the value justifies

the cost, then...

MS. ROSENBLATT: Yes. I'd just like to keep it strong.

DR. BRAUN: In three, are we talking about other sites besides --

DR. NEWHOUSE: No, we talk about that in five.

DR. WILENSKY: No, that will come -- that's in five.

DR. ROSS: Then for number four we have a post-amble that provides more discussion on why phase-in will be -- to amplify, recognizing we could be moving a lot of money around and other issues that make a phase-in needed, and we will give Jack his promissory note on analysis to come. I think that's imbedded more broadly in the entire report, but we will also do that specifically for that recommendation.

DR. ROWE: It's just that we don't want Congress to get this thing and then start making --

DR. NEWHOUSE: We allude to March 2000.

DR. WILENSKY: Yes, but I think we need to be clearer in the report that this is the first of a series of reports.

DR. ROWE: Here's the concept piece. That's what

this is.

DR. WILENSKY: Right.

MR. JOHNSON: I didn't know whether we were at the other recommendations but since this horse isn't quite dead yet I wanted to beat it again. This is, we're recommending a conceptual framework? Are these recommendations or are these principles?

DR. WILENSKY: No, I think these are -- I regard these as recommendations. We are recommending a framework.

MR. JOHNSON: I thought where the conversation left off is we would be recommending principles, but the recommendation is the conceptual framework. I don't even know if you want to say to the Congress and the Secretary should. If we're doing a conceptual framework what we're saying is, we ought to try and develop our empirical data to support these.

DR. WILENSKY: That sentence is out of the recommendation. That's not a recommendation, that part of the sentence.

DR. ROSS: But, Spence, as we had first drafted these, they were in the passive voice with things ought to be done. But I think we're obligated to say ultimately

who's going to have to do them, and to distinguish where it's going to be legislative action, where it can be regulatory. But we will add more language indicating that there's further work on MedPAC's part before those things get enacted, or considered for enactment.

DR. ROWE: With respect to the Medicare+Choice issue that we discussed a couple times earlier, you're presumably going to have that in the narrative but that's not going to be addressed at this point in recommendations because --

DR. WILENSKY: We don't have --

DR. ROWE: We seem to agree that it needs to be discussed in the context of the rest of this stuff as it rolls out.

DR. WILENSKY: Right. That was my intent.

MR. LISK: There was one other thing that Judy had mentioned and I wasn't sure where that was left off, was the statement in terms of recommendation in terms of explicitly stating that Congress should not pay directly for the direct cost of graduate medical education. So I wasn't sure where that stood in this.

DR. NEWHOUSE: I'm afraid that sentence as it

stands will be misunderstood.

DR. WILENSKY: I think that it would be better to -- I mean, I hope that we will be able to be very clear what we mean in the text and have the recommendations be, as we've discussed now. I think it's a better way to do it. I do think it's easily subject to misinterpretation.

MR. LISK: Right. I just wanted to clarify that.

MS. RAPHAEL: I liked your statement that this is the first in a series of efforts. But is the next effort going to be produced in March 2000 or will there be --

DR. WILENSKY: That is something that -- I mean, if we can, sooner is better. If we could get a product worth having at the end of the year, I think that would be better. If we can't, then we normally -- except for the last two years, which for MedPAC has been its existence -- a chapter on issues relating to graduate medical education has been an important part of the March report. So this is not burying an important issue. We have explicitly taken it out of the March report because we had the August obligation.

But my view would be, if we had something that would be a contribution to make and we could get a quarter before, I think that is a significant enough issue that we

ought to do it. But if we can't get it done by the end of the year, then I'm not sure it makes sense to have it as a stand-alone document as opposed to a strong chapter. But we can discuss that. And we discuss it actually again in September what it looks like. I think right now probably it's a little hard for staff to give a good estimate of where they'll be, unless you want to say, no, there's no chance we'll do it.

DR. ROSS: I never say never. I think March is more realistic.

DR. WAKEFIELD: With regard to, or at least related to recommendation four, it seems to me the one paragraph in text that helps to support that particular recommendation is on page 12 talking about creating that new patient care adjustment and that phase-in will hopefully provide some protection for providers, if it's not just done all in one fell swoop. And that by protecting providers, in the process we'll also do what we are, I guess, here to do, and that is to prevent an adverse impact on Medicare beneficiaries.

Here's my question. It's not to ask for language to be included specifically in this recommendation, but

rather to say, could it be in that discussion related to that recommendation, might there be an angle there that speaks specifically to health care infrastructures that may be particularly vulnerable?

I'm right now thinking of Medicare beneficiaries who access health care services in rural areas. So that phase-in, it seems to me, might be especially important for any parts of the health care sector that are vulnerable, for starters. I would just throw out the example of rural as an example. So might that be fleshed out a little bit more in text that seems to relate to that recommendation? Would that be acceptable? Because it seems to me that added protection there is --

DR. NEWHOUSE: This is now on the enhanced system as opposed to GME?

DR. WAKEFIELD: That's correct. And patient care services, that's correct. Yes, just so that in that report we're saying very clearly, we've got vulnerable sectors of this health care delivery system and we, through this phase-in, think that attention needs to be paid there probably especially, but throughout the system looking at impact.

DR. WILENSKY: That's clearly why you're doing it,

why you want to have the phase-in.

DR. WAKEFIELD: Yes, and with that special attention to those facets of the health care delivery system like rural health care infrastructure.

DR. ROWE: Gail, if this is the concept piece and we're laying out the general idea, I wonder if -- and I'd be interested in commissioners and particularly Joe's view since this is, in the main, his idea. What are we expecting the impact this will be on the cost to the Medicare program? That's one of the questions -- Congress is going to pick this up and say, is this a reduction in cost or expenses? Is this budget neutral? Is this an increase in cost? Somewhere maybe we should have a statement saying what we think this would do.

The non-technical people might be looking at this saying, is this going to help me cut the budget? Is this an enhancement? What's your view of what the impact would be of what --

DR. WILENSKY: Small. Small in the aggregate, maybe slightly a saving of money. But I think that when we talk about the empirical estimate, about the work we will do empirically to reestimate the cost of care in these for

purpose of enhanced payment --

DR. ROWE: Refined DRGs.

DR. WILENSKY: -- we can talk about it. Well, refined DRGs, I don't think ought to have --

DR. ROWE: That should be neutral, right?

DR. NEWHOUSE: No, actually that's where I think there may be more of an impact. Just shifting direct into indirect I think will be neutral.

DR. ROWE: Then maybe we should say that.

DR. NEWHOUSE: But if you can knock down the coefficient on the resident to bed ratio, then that over time will, I suspect, lead hospitals to decrease their number of residents, and that means --

DR. WILENSKY: He means now. He's not talking 10 years from now.

DR. ROWE: No, I'm just trying to say the policy implications. We've agreed this is our concept, and I think one reasonable question is going to be, what --

DR. WILENSKY: I think it's going to be very small.

DR. NEWHOUSE: The short run, first order effect should be neutral.

DR. ROWE: Maybe we should have a statement in here somewhere that if this is activated along the lines of what we're considering it to be -- because people are going to misconstrue this according to their own ideas -- we would predict that this would have --

DR. NEWHOUSE: It also at some point depends on these other settings.

DR. WILENSKY: But we can at least put in a statement that our expectations are whatever.

DR. ROWE: This is not a mechanism for major reductions in Medicare expenditures, or something like that.

DR. LAVE: I think we have to make an explicit statement that this is not intended to be a cost-saving device, for the following reasons. Forget about --

DR. ROWE: That's my point.

DR. WILENSKY: But that's a different point.

DR. NEWHOUSE: Forget about what?

DR. LAVE: I think we have to make a statement about whether -- if this is implemented, should one think about it as being implemented in a budget neutral fashion? For instance, let's just take the APDRGs --

DR. WILENSKY: No, wait a minute, that's a

different issue. I think it will be close to being a wash--

DR. LAVE: It can't be, because if you take the APDRGs, Gail, and you restructure them -- if you think about any time the government restructures its weights, it does it in a budget neutral -- it makes an explicit decision that the base payment that will be made will be budget neutral given this. So it makes an explicit --

DR. WILENSKY: You're talking about the DRG as opposed to the education.

DR. LAVE: But we're making this all together. You can't do one without the other. If you do the APDRGs -- you have to do the APDRGs and the teaching adjustment together, because the APDRG estimate is going to make a difference with respect to what the coefficient is on the --

DR. WILENSKY: I would think that you have to do -- I agree with you on the first portion. That is, that the refined DRG calculation ought to be made budget neutral and it ought to be done first, at least conceptually. And that the other is an empirical estimate, which I think will be close to a wash, but I don't think there's any reason to declare it literally budget neutral at the start.

DR. LAVE: But why wouldn't you want to do the

totality budget neutral? I think it's the totality of the money that -- we're not talking budget neutral with respect to the teaching hospitals. We're talking budget neutral with respect to the overall system.

DR. ROWE: We agree it's going to be a lot of money moving around.

DR. WILENSKY: No, that's a different issue.

DR. LAVE: It's going to be a tremendous amount of money sloshing around, and the APDRG system is going to affect the -- I think it's very peculiar to think about changing the DRG system, recalculating the IME, pulling that money out, then going through and doing the IME thing. I think that you do the whole thing as a package and then --

DR. WILENSKY: Let me give you an example. As I say, I think it's going to be close to a wash, but I think making budget neutral on the DRG calculation is perfectly reasonable. It's the first thing you would do.

The issue with regard to whether or not the cost associated with looking at what has been direct and indirect, looking at the effect of the costs on patient care and trying to explain the correlates of this enhanced patient care may or may not be -- I mean, we have thought in

the past the IME was somewhat overstated.

DR. NEWHOUSE: There's that. There's also the issue of whether you use --

DR. ROWE: And the DME is understated.

DR. WILENSKY: And that's why I think it's a wash.

DR. NEWHOUSE: That's right. That was going to be my point.

DR. ROWE: It's your idea, Joe. What did you have in mind?

DR. LAVE: But it depends how we think about this. Are we thinking about this as a totality changing the system, making it budget neutral towards where it is, that the government put us budget neutral when you put into effect the reduction in the IME.

DR. WILENSKY: We were not attempting to do this as a cost-saver. I agree that we think there is an overpayment in IME, and perhaps an underpayment in DME, and that's why we think that they're as close to a wash. But it's an empirical issue is what it is, and not a conceptual issue. Whereas, the reweighting of the DRGs is something that one does, and typically does, budget neutral.

DR. LAVE: So you're going to reweight the DRGs on

what decision with respect to the IME and the GME?

DR. WILENSKY: That is at least conceptually how we're approaching this.

DR. NEWHOUSE: The practical implication for the numbers is, do you put the actual resident salaries' cost into the regression, or do you put the 1984 costs trended forward? I would personally put the actual costs.

DR. WILENSKY: Absolutely.

DR. NEWHOUSE: That leaves open the issue of, then do you use the empirical level when you come to pay for it, or do you pay more than the empirical level as we are now doing? But that, to me, comes later.

DR. LAVE: I agree with that, too. But I guess that what I find difficult to think about is that you're going to do it in two parts. That you're going to make it budget neutral with respect to everything taken together including the coefficient and the payment on the IME and the DME, or whether you're going to do it budget neutral with respect to pulling out money that would have gone to IME and DME and redoing it.

DR. NEWHOUSE: It seems to me we ought to have -- this is a discussion we ought to have after we see the

numbers. Because if the numbers are very small, maybe it's all moot.

DR. WILENSKY: Which I actually assume that they are close to being a wash, but it is not obvious why you would make that as a statement of principle with regard to the IME-DME. Whereas, having it with regard to the DRG recalculation is in fact -- that is frequently what is done in terms of a reweighting. But I think that our expectation, the way this started was, should we include -- and I certainly have no objection to doing it -- that our expectation is that this is close to a wash in terms of money. This is not being done as a cost-saver, and it is not anticipated that it would have a substantial or a large effect on total spending.

DR. ROWE: Or significant. I think that's fair. I think just based on the fact that two reasonable health economists here have a different view of this in MedPAC and many in the Congress -- only half or two-thirds of Congress are health economists --

[Laughter.]

DR. ROWE: And those that aren't, they're just going to want to know, is this another cost saving thing or

is this another attempt on the part of the AAMT to increase costs, or what is this? Somewhere we should have a statement that says, no, this was why we did this. I just think it should be -- and if it belongs anywhere, it should be in the concept piece. Then we can say, more to come on this when we do the analysis.

DR. WILENSKY: At the very least, saying it's our expectation that this is close to a wash in terms of budget terms, but at least --

DR. NEWHOUSE: Has a minimal effect on total expenditures.

DR. WILENSKY: Thank you; minimal effect on total expenditures.

DR. LAVE: Right, but I think you have to make that decision a priori.

DR. WILENSKY: I don't think you can and I don't think you should. But I think it is where you're going to be, because we have enough sense about what the numbers are going to look like.

DR. LAVE: If you didn't change the DRGs, I would agree with you, that it would be budget neutral. But one of the things that happens when you do the APDRGs, I think, is

that you would -- the question is, if in fact some of the money that is tied up with the IME is really patient care stuff, then you may want to have more money go under that bucket.

DR. NEWHOUSE: But that's still budget neutral from the point of view of the whole system. The biggest aspect of budget neutrality seems to me to raise the issue of what are you going to put in for upcoding, if anything, when you do all this?

DR. LAVE: Budget neutrality for the whole system I think. The question is how do you get there. I mean, how you do the analysis.

DR. WILENSKY: Again declaring -- I think, our expectation that this is close to a wash in terms of budget terms and that it is not anticipated as a budget saver or a budget coster, and that at least conceptually we would like to have the IME-DME issue be an empirically determined issue, to the extent we can do that.

DR. KEMPER: I guess I'm puzzled because based on the document -- granted, it's a data-free environment, but just based on the directions that these sentences that sort of weigh it, well, this would have an effect in this

direction and this would have an effect in this direction. It sounded to me like the logic would be a reduction in payments. Because it seemed like the effect of putting the direct payments in the patient care costs was less than the effect of adjusting for trending the costs forward. I mean, the net effect. I actually wonder if we don't know more about what the effect would be than the --

DR. NEWHOUSE: No, it's more.

DR. ROWE: It's more. It's 35 percent --

DR. NEWHOUSE: Yes, the two doctors agree on that.

DR. KEMPER: So you're saying that it would actually be an increase?

DR. ROWE: Yes.

DR. NEWHOUSE: Then it gets to where you do the empirical level on the IME side.

DR. ROWE: My understanding of this, which is of course superficial, is that the Medicare program in Congress and in MedPAC consistently points out that the IME payments are in excess of the calculated cost of IME, and is therefore a subsidy. What is less well articulated is that the DME payments are 35 percent less than the actual DME costs, which would seem to be a subsidy afforded the

Medicare program by the teaching hospitals.

So to some extent if you throw this all --

DR. NEWHOUSE: So those should offset.

DR. WILENSKY: That's right. I think empirically they will be close to offsetting because it's 35 percent of a smaller number, as opposed to an overstatement of a larger number. And when you put them together it may be a slight reduction, it may not be.

DR. ROWE: We'll see what it is.

DR. WILENSKY: But whatever it is, it is not likely to be a big number. But it will be what it will be empirically, not what we say by fiat.

DR. KEMPER: Then to my way of thinking, it would be useful both to make the statement, as was suggested, that this is not intended as a cost-cutting change, and to say a little bit more about what we know empirically about the likely --

DR. WILENSKY: What our expectations are.

DR. ROSS: To come back on the intent. I guess Judy's point finally sunk into my skull. In talking about DRG refinements as being budget neutral, I think we make in the text -- and if we don't, I do think it's appropriate at

this stage to talk about -- when you pull money out to reflect higher case mix that's currently being paid out through the IME adjustment and put it back into the base rates, I think the assumption that I carry in my mind is that more money is in the base rate pool.

DR. LAVE: Right. That's why we --

DR. ROSS: That's what we mean by systemic budget neutrality.

DR. LAVE: That would be not budget -- that's why I think you have to look at the whole picture and figure it all out in the totality. You can't do it in the two parts.

DR. WILENSKY: But the problem -- I mean, with regard to the transfer, I agree. But with regard to this issue of what you're doing between the IME and DME --

DR. LAVE: I have no problem with that.

DR. WILENSKY: -- you ought to allow in principle that you either pay a little more or a little less, depending on whether or not --

DR. ROWE: How it works out.

DR. WILENSKY: -- the DME underpayment is larger or slightly smaller than the IME overpayment. And I don't know what the answer is, and whatever it is, it is.

DR. LAVE: I have no problem with that. My problem is that when you change the APDRGs --

DR. WILENSKY: No, I agree with that.

DR. LAVE: -- it changes it in ways that you have to decide what you want the baseline, when you do all the reweighting --

DR. WILENSKY: My concern was that by saying we will, by fiat, declare it budget neutral overall, we disallow for the fact that the net change with regard to the IME and DME may not be exactly budget neutral and that we ought to be agnostic on which way it turns out.

But I agree with you that moving some of what had been education expenses into the DRG to better reflect complexity and severity would increase that baseline.

DR. LAVE: That was my point.

DR. ROSS: What I'm hearing you say at this point is that you do want a statement of intent. That this is not intended, again, as either a cost or a saver.

DR. WILENSKY: Right, and it is not our expectation that it will do much one way or the other.

DR. LEWERS: In the text.

DR. ROSS: In the aggregate.

DR. WILENSKY: Yes, definitely in the aggregate.

Why don't we try to have the discussion of five, which is a very important issue that has been raised several times this morning, which is what happens with regards to other settings and other providers.

DR. NEWHOUSE: The problem with five as stated is it's just a corollary of one.

DR. LEWERS: That's right.

DR. ROSS: Yes. We just wanted to be -- you know, do you want to be explicit on it?

DR. WILENSKY: Which is what I think we intended. In concept, that is what we intend. Whether we will actually be able to do it empirically is less clear. But I think in concept that is what we would like to do.

DR. ROSS: If I could just add for from staff, empirically not by March.

[Laughter.]

DR. WILENSKY: Right. But I think it is at least, or it ought to be regarded as a signal that we are not saying this is inappropriate. In fact we're saying just the opposite. That in principle we do want to extend this to other providers in other settings, and the question is will

we be able empirically to do this?

MR. MacBAIN: We probably should reword this to reflect Joe's rewording of the first recommendation based on Alice's concerns about cost.

DR. WILENSKY: Any further comments? Bea and Mary, does that at least increase the comfort level that it's our intent to try to deal with this?

DR. WAKEFIELD: Yes, and actually Joe's comment helped me as well in drawing a parallel or a corollary between this recommendation and the first. Because when I saw that first one put up there in front and then didn't get to this until the fifth recommendation -- I guess it's the fine-print issue, Murray, but you just helped me through that.

MR. MacBAIN: Put this in the front.

DR. WAKEFIELD: Yes. As long as it's there and it's viewed in that context, I'm fine.

DR. WILENSKY: It is 1:08. Why don't we reconvene at 2:00?

DR. ROWE: When do you think we'll be done?

DR. WILENSKY: It depends on how long the public comment goes. I think we will be done with our portion

by 3:00 and I would like to allow for whatever time -- obviously, if the commissioners choose to speak more than an hour when we reconvene, we will.

MR. SHEA: Gail, can I impose on my fellow commissioners? I'm not going to be able to be here after lunch. I just want to make one comment. I just wanted to weigh in on number six with the suggestion that this specific recommendation be removed as a recommendation. There is text which talks about the core mission -- we've talked about that -- which I think is appropriate with some of the adjustments we've had. I don't think that we need to have this as a recommendation and I would suggest that it be omitted.

DR. ROWE: We talked about that earlier.

[Whereupon, at 1:07 p.m., the meeting was recessed, to reconvene at 2:00 p.m., this same day.]

AFTERNOON SESSION [2:13 p.m.]

DR. WILENSKY: Hugh, you indicated you'd like to raise an issue?

DR. LONG: Yes, this is actually revisiting something that we mentioned this morning. Bill and I had a chance to talk a little bit during the break and I also chatted with staff. I just wanted to raise this because I'm not sure what the commissioners pleasure might be.

It seemed to us that there are several places where in the preamble materials before we get to the recommendations in the body of the report, we seem to make some fairly categorical statements, some of which I think we subscribe to but which took us a long time to get there through a lot of intermediate steps that we haven't necessarily put forward in this text.

I'm in particular thinking about the last paragraph on page one where we come to this conclusion and say that hospitals -- the cost of providing enhanced patient care are in fact the sum of recorded direct and indirect costs. On page four, in the last paragraph of text,

hospitals should be unwilling to pay for such training costs without any mention of possible subsidization. On page five, the two middle paragraphs right over IV where we have the formula, and then in the next paragraph where you say, since residents are paying for the cost of their training, Medicare is not paying for training costs.

In each of these instances, these may be correct statements given some assumptions and preliminary steps that we made or subject to some caveats about availability of IMGs, some other things. Bill and I have done some inequalities, we've done some bar charts, we've done a couple of things that may or may not be useful which might best show up in an appendix or whatever.

But it's just our sense that in terms of communicating the process we went through, we need to do a little more, and we need to put some qualifiers in some of these statements, without changing any ultimate thrusts. But also then again, as I mentioned before, distinguishing between our description of the world as it is today with IME and DME as we have structured it, and the world to which we aspire.

DR. WILENSKY: I agree. I think it's important.

We have had both some sidebar discussions as well as some general discussion about the fact that as a result of Medicare policy there are some changes that exist now that reflect the world as we know it, and we need to recognize that.

The issue of how to put the context of this discussion, for the recommendations, will be very important. Again, to make sure that they capture the right order in which to introduce these concepts is something that I think will take a little bit of thought to get right.

Any other comments before we continue through?

We had gone through the payments and other teaching settings, and I've spoken briefly with both Bea and Mary. My sense is that you're comfortable with that.

The sixth one was one that Gerry Shea requested that we delete and just keep the discussion in the text, but not make it a specific recommendation. Is there any objection to that?

DR. KEMPER: I actually would go one step further and take it out of the text as well, at least with respect to the research and development and uncompensated care. It seems to me we don't need to get into that in this report.

I think we do need to get into the issue of labor force or workforce and that comes next. But this not only appears in the recommendation but also appears throughout the document as a pretty pervasive point. I guess I would argue that we ought to take it out of this document because it's not really what this is about. This isn't about disproportionate share and other aspects of Medicare it seems to me.

DR. ROSS: You will need to come back to this one, I guess in March, when the discussion is on whether the empirical adjustment and the policy adjustment and the estimated adjustment are one and the same, because that's what that feeds into.

DR. ROWE: Isn't there a risk -- I'm not sure I support -- I don't want to support leaving the recommendation in, but I do want to support leaving some language in with respect to disproportionate share needs. If the whole idea here is that we're going to pay more to teaching hospitals than we do to others because we think there's a better, more valuable, or more accessible, whatever service being provided and we're trying to account for that in various payments, some of that gets lumped into

what we used to call GME is really enhanced patient care. But there are these other payments too and it's all part of what's getting paid to these institutions.

DR. NEWHOUSE: Uncompensated care is on the revenue side. These other things are on the cost side.

DR. ROWE: DSH is on the revenue side.

DR. NEWHOUSE: I know. So it would be "the cost of uncompensated care." I mean, it's really a foregone revenue; a person doesn't pay. You still have the cost of treating them showing up in the cost report.

DR. ROWE: I guess what I was reacting to was the fact that we want to purify the discussion down to a GME-one kind of discussion, collapsing that into this one payment as if these other payments didn't exist or weren't valid or weren't important or shouldn't be increased or decreased or something else. It just seems to me that it's valid to have them in the discussion. I just don't feel strongly about having this recommendation. This gets a little beyond our--

MR. MacBAIN: I think the recommendation though, as written here, would move payments, would move for things such as DSH from the current Medicare payment stream and put it into an annual appropriation. I think that's what

Gerry's uncomfortable about. I know that's what I'm uncomfortable about. I don't think that's what we mean.

DR. KEMPER: And that's what I'm uncomfortable with.

DR. ROWE: I'm with you there.

DR. KEMPER: That's what's troubling me. But it troubles me throughout the document, not just here.

DR. NEWHOUSE: But I agree, on a report on GME we don't have to reach that issue.

DR. WILENSKY: I think, actually consistent with some of the philosophy that's in here, that is consistent with where it would suggest you would go. But we're not asked at this point to opine on that, so I don't know that we need to get into that.

MR. MacBAIN: It's another two-year discussion.

[Laughter.]

DR. WILENSKY: My sense then, unless there is someone who wishes to speak otherwise, we will take out both the recommendation and the text relating to this point specifically.

MR. LISK: You may want to have some other text, and I have to think about it in terms of how you do this.

Because some of this relates to other activities that teaching hospitals do, particularly like research, which is some concept maybe incorporated in -- some of those costs may be incorporated into what is captured by the indirect, if they translate into higher costs and are highly correlated with the presence of residents, for instance.

So in terms of the definition of trying to pay for the efficient cost of a provider, that is in one context of why we thought this was part of that debate. So I'm not sure whether some of that discussion -- you may still want to have some discussion in there related to that. So that's why I just wanted to --

DR. WILENSKY: I regard it more as what you would try to knock out. What we've acknowledged is that teaching institutions have higher costs, and we think in general those higher costs are associated with a service that has enhanced value, and therefore we want to pay for it. If we follow the logic of focusing Medicare on making sure there's access to services for our Medicare population, you might want to say, but we ought not to include as part of Medicare payment those things which are really somebody else's bailiwick.

Now the fact is, empirically we're probably not in much of a position to say what that is, and politically it's certainly not likely to happen. So I would say that if we have this discussion in, it suggests knocking down some of the allowable costs and not including them.

DR. KEMPER: I have no problem with that aspect of it, but the way it's written in here it's a much more general philosophical issue which for me takes it to DSH, rather than knocking out certain costs from the cost report.

DR. WILENSKY: I would agree. I would say that the statements in here, if they haven't raised in people's minds why exactly Medicare is paying for DSH when we don't really think it's an access to hospitals for our seniors, it should have crossed your mind, but that is the logical extension. So we don't need to get into that.

DR. KEMPER: That's my point.

DR. LAVE: I also would point out that we have a number of recommendations on DSH which are not exactly consistently with this. We do have a whole -- I agree with you with the logic, but I would also point out that ProPAC made a number of recommendations about how the DSH formula should be restructured.

DR. WILENSKY: As did MedPAC.

DR. LAVE: And MedPAC concurred with those. And we had a very long discussion at that time about what was the purpose of DSH. I don't know whether the argument that we gave at that time was perfectly consistent with this argument, although we did sort of say that if the hospitals weren't open, Medicare people couldn't get there. But I think that we may want to have this less --

DR. WILENSKY: Let me remind people, at least as I recall, we've had two discussions of DSH in our March reports. We basically chose to punt on the question about whether DSH was really an appropriate Medicare issue. But rather said, if we were going to have DSH payments, that having a threshold different for rural hospitals and for urban hospitals, and having the kind of distribution and the definition of uncompensated care made no sense.

Because I think, although you can make the statements that if there weren't DSH payments there might be access problems, in fact I think you would probably not be able to sustain that argument too long. So we just chose to take what I think was a reasonable position, given that we had been asked to comment about the DSH program, that if you

are going to have such payments you ought to make sure that you don't have these unlevel playing fields between urban and rural and that you have a more sensible definition of uncompensated care, and really just didn't deal with the issue about why is this Medicare.

I would think that that would suggest here just having less conversation about these issues here. We don't need to have that discussion here I don't think. I think that it's only to the extent -- there may be some empirical issues that we will have to deal with when we attempt to estimate the appropriate allowable costs that we're trying to account for. But we will do that within the context of what it is we're trying to estimate.

So if that's all right, I think both taking out the recommendation and not having general discussions about these issues would be better.

Okay, number seven.

DR. LAVE: I have no problem with this recommendation. However, in deference to my role as a Medicare commissioner I would point out that we probably --

DR. ROWE: And the child of a 92-year-old.

DR. LAVE: Going on 93. But I will tell you that

she is being taken care of under the Canadian health care system so my recommendations will not influence the care that my mother gets. So having said that...

But it does strike me that -- I think that we should point out that the prices that we pay for services which are provided to Medicare beneficiaries, recipients primarily -- that is, that they are predominantly received by Medicare beneficiaries. And if there are a certain set of suppliers; i.e., geriatricians, that treat that patient, then Medicare payment policy will more directly impact that market. So I think that for part of the market that our payment policies are much stronger than are stated here, and I think we have to say that.

DR. NEWHOUSE: The question is whether we have to say it in the recommendation.

DR. LAVE: No, I have no problem with the recommendation.

DR. NEWHOUSE: That Medicare policies will affect the workforce is undeniable.

DR. LAVE: No, but basically I'm looking at discussion here where you say, supply mix. But we don't really point out here that there are certain types of

services that are used primarily by Medicare beneficiaries, and how we pay for those -- that may be supplied by certain types of providers, and how we pay for those, will have a larger --

I mean, Medicare's payment policies are going to affect the supply of geriatricians. If we don't pay for the services that they provide, we won't get them.

DR. WILENSKY: Now are you suggesting this as a part of the text or as a part of the recommendation?

DR. LAVE: As part of the text. That there has to be a stronger statement that --

DR. NEWHOUSE: Maybe to make the text consistent with that then we need something like, in general, or insofar as possible, that preferences the recommendation.

DR. LAVE: That's right. But I just think that we have to realize that --

DR. WILENSKY: $200 billion will have an influence.

DR. LAVE: $200 billion will have an influence, and that there are certain providers --

DR. ROWE: As stated, the recommendation is wrong.

DR. ROSS: Why don't we clarify the intent of the

recommendation by putting in something like, policies intended to affect federal health workforce, as opposed to, policies intended to provided health care services that incidentally affect workforce?

DR. LAVE: Yes. I mean, I don't think you want to do targeted -- but it's just this interaction has to be explicitly recognized, particularly for services which are used primarily by Medicare beneficiaries.

DR. ROWE: I.e., and we can list them.

DR. LAVE: We could i.e., geriatric assessment. I don't know what they are: end of life care. We know there are going to be -- how we pay for services are going to influence the providers that come forward to provide them.

DR. LEWERS: I agree, and I think it should be in the text. I don't have any real problem with the recommendation except again trying to spell out some of the specific targeted programs. I'm not quite sure that's going to be clear to individuals interpreting this.

We've spent the morning talking about a number of issues and we've said on several occasions that the resident-to-bed formula has brought forth an excess of residents. But we don't have any evidence to say that. We

all believe that, and there is some empirical evidence to suggest that. But that's a workforce problem that we've impacted. And I think for us to be silent on this is wrong. I agree with Judy. I think it should be in the text, however.

But I need to ask Murray, we were directed to look at workforce issues by the BBA. What we're saying to Congress, I am assuming, is that we don't agree with them; that it's not our choice. I think what they said is, they don't have anybody else to do it, so you guys are pretty smart, you do it. So I think somewhere we have to address that it's just -- it's not a Medicare issue. But I've got a feeling they didn't give it to us as a Medicare issue. So I just wanted to bring that point out.

I don't know what the feeling, what your comments with the Hill have been on that. I just think we need to put some comment on how we are impacting it, but that this is not something that is directly related to Medicare. It's a much broader context. That's why I don't have any problem with the recommendation. But there needs to be more in the text rather than a paragraph.

DR. WILENSKY: But I think that when you look at

the BBA charges, there were overlapping directives to three different groups. That's why, although I agree with your bottom line direction that we need more discussion of this issue, and particularly acknowledging the fact that a $200 billion program will have effects on the supply of services and professionals as a result of that.

But there were directions that overlapped with direction given to the bipartisan commission, and more importantly for this purpose, the directions to the Secretary in terms of producing a report. So I don't think we have to look at this as though we are the only group that has been asked to look at most of these issues. Most of them, although not all of them, had some overlapping assignment.

MS. RAPHAEL: I'm trying to get the salient points here. One of the things that impressed me in our discussions at the retreat was that Medicare is an ineffective instrument of effecting change in the workforce. But we are saying here that Medicare payment policies should try to avoid distortions in that marketplace.

DR. NEWHOUSE: Yes.

MS. RAPHAEL: Are we also saying that Medicare

payment policies should try to enhance certain elements of the workforce?

DR. WILENSKY: Not unless you have some strong reason to believe that with appropriate payment that there would be some need for intervention. I think in general our attitude has been that if we don't distort the payments, that would be adequate.

MS. RAPHAEL: That's what we want to attain.

DR. ROWE: I thought what we were saying was that we are focusing our concern on access to services.

DR. WILENSKY: Right.

DR. ROWE: And that issues related to workforce are secondary. To whatever extent changes in our payment policies are aimed at enhancing access to services that we think are valuable and currently not as available as optimal, then that might have an effect on workforce. But that would be a secondary effect. Our concern is access to services on the part of the beneficiaries.

DR. WILENSKY: That's correct.

DR. NEWHOUSE: Also, the first order effect for things like geriatric assessment is going to come through payment for the service and not through the GME setting.

DR. WILENSKY: Right.

DR. ROWE: That's what we're saying. That's what I thought Judy was saying should be in here, and that we are aware -- we are not so naive as to think that this program doesn't influence workforce. But we want to influence it through the mechanism of services because we're concerned that otherwise we may not get the services, we'll just wind up spending the money.

MR. MacBAIN: A couple of points on this. One is, I think we've got an inconsistency. Earlier in the report, I think it's on page 11, we're recommending continuation of the per-facility resident caps in the BBA in the context of the resident-to-bed ratio. If we're eliminating our belief that the resident-to-bed ratio needs to be part of the formula, then we've also eliminated that need, which brings us into -- which lets us be consistent with this.

Otherwise we're saying on the one hand, no, we shouldn't have Medicare get into the question of the number and mix and geographic distribution, but it should still continue to impose caps on the number of residents, which is exactly what this says now.

DR. NEWHOUSE: What if we added a sentence?

Something like, insofar as possible, Medicare should avoid distorting the market, which would then speak to the rationale for the caps.

DR. ROSS: You've identified a basic conflict between two constraints that you're not going to be able to escape. It's one thing to say that we've eliminated the resident-to-bed ratio from our thinking, but it's not clear that we've eliminated it in any practical sense.

DR. ROWE: Sure we have.

MR. MacBAIN: This is a theoretical framework. We can eliminate from that in any event.

DR. ROWE: We've eliminated the incentive completely.

DR. ROSS: But that statement to which you're referring, Bill, is again to the -- if you're in a world of the second best and you're working with a measure that's a proxy for the enhanced patient care, you're going to have some unintended consequences. And one of the things one could do with those unintended consequences is preserve the provisions in BBA. You don't have to say it that explicitly, but just --

DR. WILENSKY: I think that what we can do,

because at this point we have not resolved what the empirical estimation is going to actually look like, we can couch it in a more conditional manner. Which is that if we are able to come up with a formula that does not have the unintended consequence of encouraging more residents, then there would not be a need for this to continue, if we are not able to do so.

MR. MacBAIN: Except as necessary to avoid distortions elsewhere in the payment stream.

DR. WILENSKY: Exactly.

MR. MacBAIN: The other point is, in reading the paragraph under the recommendation it seemed to me that we were saying more than we meant to. We were talking about more than just workforce policy. I read this as questioning critical access hospitals or other modifications to payment that deal with exactly the issues of improving access in -- the last line of that second paragraph, broader issues related to access to care for select communities, is indeed something that Medicare does do through its payment policies and in the past we've supported.

So I'd feel more comfortable either removing that whole paragraph or rewriting it to focus it only on

workforce issues.

DR. WILENSKY: Yes, I think when we go back to reflect the other comments there needs to be sensitivity to this, that what we're reflecting on is the workforce, not uncompensated care, not the DSH issues, and not these other issues as well.

DR. WAKEFIELD: On that same paragraph that Bill was speaking to, the one line in that paragraph that just creates a bit of a problem for me is the second one that acknowledges that some beneficiaries will or may have difficulty obtaining care because of under-supply of professionals in their community. Without a doubt, I agree wholeheartedly with the second part of that sentence saying, this isn't just Medicare's problem. This is a much broader issue for under-served communities and vulnerable populations, et cetera. It isn't just Medicare's problem.

Further on we say, step up to the plate and ensure that policies don't distort the market. But it seems to me, and maybe I'm just sensitive to it and shouldn't be this way. It seems to me that that language, they may have difficulty obtaining care, strikes me as a, well, you know, that's sort of too bad. They may have -- it's almost an --

there's an insensitivity to that notion, from my perspective, and perhaps even to what it may represent.

I guess my question is, does the Medicare program have any obligation to help meet the needs of those beneficiaries? Again, recognizing that that's our -- I agree wholeheartedly, this is a bigger issue than just Medicare's issue. But that phrase is a bit problematic for me.

DR. WILENSKY: I think that what we may want to do is reference some of our other reports. After you've gone through a couple of these cycles you will start to hear things that sound very familiar. We have, on numerous occasions, at least a half-dozen years in PPRC when we were doing access to care reports, indicated that as best we could tell there was not systematic access problems for the Medicare population. The few places in which there appeared to be so-called hot spots were places in which there were clearly recognizable problems that were not uniquely related to Medicare.

So this is an issue that we have dealt with repeatedly. That when this has occurred for the Medicare population it is because they are living in an area where

there are major access problems.

What we may be able to do is just to have a reference. So this was -- again, for those of us who have read through those chapters a half-dozen times over a half-dozen years, it evoked a whole string of other comments that went with it. But we can't assume our readers, nor our new commissioners, have that, so I think it might be helpful to just reference some of this so that we get people to understand the context in which we make that statement.

DR. WAKEFIELD: That, and I think your point just supports the latter part of that very same phrase -- I mean, basically that's what you're saying, it's been reflected in previous reports. That is, I think there are broader issues, there are hot spots. It isn't just Medicare beneficiaries adversely affected, it's kids, it's whoever else might be residing in that community, wherever it is. I understand that.

I guess my question is still, is there any responsibility on the part of the Medicare program beyond support for things like critical access hospitals, et cetera? Is there any responsibility through Medicare for access to providers, ensuring that?

DR. WILENSKY: I think our assumption has been in the past that resolving that problem is too big for Medicare to do. Medicare is, somebody used the term, a very inefficient instrument to try to resolve what is a fundamentally bigger -- an issue that is not related to Medicare policy, per se, and that is unlikely to be resolved by Medicare payment policy. That it has to do with other areas. We can try to, again, reference some of the work that both MedPAC and earlier commissions have done on this.

DR. WAKEFIELD: I understand your point.

MR. MacBAIN: Just to follow through on that, particularly since we've removed recommendation six, we may want to throw back in a few words saying, these are important issues, important to the commission.

DR. WILENSKY: Right.

MR. MacBAIN: We're not saying that the government shouldn't do something, or somebody ought to do something, just not through Medicare payment policy.

DR. WAKEFIELD: Right, that would be helpful.

DR. WILENSKY: Further comments from the commissioners before we go to public comment?

Okay, let me open it up to the public. If you

want to speak, identify yourself and please try to keep your comments and questions short.

MR. ZICKLER: Thank you, Madame Chair. I'm Bob Zickler from the Association of American Medical Colleges.

First, I want to take the opportunity to thank and commend the commission for the very thoughtful and far-reaching discussion that you've had. You've spent an enormous amount of time on this topic. I think we've all benefitted from hearing your insights, and clearly your report will benefit from the discussion and challenging that has gone on between commissioners and the staff.

As I listen to the discussion, and as we've thought about the conversations of MedPAC on this topic, I'd like to make a suggestion and then a comment. The suggestion is that, at least from our perspective, the commission is proposing a framework that will replace a framework that has been in place for -- depending on your perspective -- 15 or 30 years. Namely, that it is appropriate for Medicare to pay for graduate medical education.

There are many references and committee reports. It's clearly part of the statute. It's clearly part of

regulation.

I have not seen your report, and it may already contain this, but it strikes me that it would benefit Congress and others to have the old framework and the new framework juxtaposed against each other, and the relative strengths and weaknesses of each framework articulated, as well as the consequences that the commission feel need to be dealt with, that are best dealt with in the new framework versus the old framework.

I recognize that some of you feel the old framework may never have existed or was never appropriate. But nevertheless, it is one that has been in place. And I think as people try and understand the new framework, that that would be of value.

The second comment I'd like to make really stems from that, and that is to ask the commission in its continuing deliberations to consider the ramifications of Medicare essentially adopting a position which says it is inappropriate for Medicare to support graduate medical education.

I think that is the headline of the framework that you have proposed in your discussions today, and that I

anticipate that you are going to adopt.

We tend to believe that there are a number of ramifications, maybe some of which are unintended, that may emanate from that decision. And we believe that it would potentially undercut one of the strengths of Medicare's historic policy, which from our perspective has been to promote quality graduate medical education, to help move the field away from an apprenticeship type system to one that focuses on educational content, educational quality, accreditation, and the resident as a student versus the resident as a pure provider of service or employ.

We do not believe it would be in the interest of the Medicare population, of the general public, of medicine, to move away from that position. We believe we're all well served by an educationally oriented graduate medical education system. And I believe personally that all or most of you believe the same.

But it is possible that when Medicare declares that graduate medical education should not be supported by Medicare, that then is picked up by other payers such as Medicaid and private insurance, who say we too should not support it. And we then move into how you implement the new

framework.

You may inadvertently undercut some of the very structure and fabric of graduate medical education, whether it be accreditation, who is a resident, the value of education, and its import for the future of society and the quality of health care in the United States.

Now I know how difficult it is to prognosticate the future, but I think those are topics of such import that to the degree you can include them in the things which you are going to investigate, and even hold out the possibility, if you consider it appropriate, that as you explore the consequences of the new framework versus the consequences of the current framework, that it may be that while the new framework has better appeal and better roots in economic theory, its actual consequences may not be better in practice than that which we already have in place. And therefore, it should potentially not be adopted.

We look forward to your written report. We look forward to the opportunity to comment on it, and to continue to work with the commission and the staff and all of the interested parties on these issues.

Thank you.

DR. NEWHOUSE: Thank you, Bob. You bring up a point that had occurred to me, and that we should probably have discussed, which is going back to the original statute, about Medicare was to pay for its share of medical education costs.

I think the logic of where we have gone is to say that, in practice, those costs are going to inevitably be borne by the resident, so that whatever -- Medicare's share of zero will still be zero.

The logic, however, that we have holds for the other payers as well. For example, Medicaid should also talk about whether it wants to pay for the product of the teaching hospitals. But I don't know that we can answer that. But thank you for your points.

DR. WILENSKY: Again, I think the issue that was raised with regard to the framework of trying to get people to understand how we are looking at this issue, and how at least the verbiage of the past setting looked at the issue will be very important. I think we've been very careful to say that we are not going to use terms so that people -- whatever they paraphrase -- will not be able to direct quote our saying a recommendation of not paying for graduate

medical education, because we're not having that as a specific recommendation. But what we are going to try to be very clear of us saying that we want to be sure that seniors have access to the enhanced services that go on in teaching institutions.

We think that's basically what we were trying to pay for previously. We're going to try to acknowledge it explicitly and do a better estimation of making sure that we are not going to shut out seniors from these more costly institutions that are providing a service that we think represents enhanced patient care.

Whether we will be able to change how people both think about and talk about Medicare payments will be a challenge. One of the interesting exercises that I tried to do when I was at HCFA is to press the concept of coordinated care rather than managed care because it wasn't clear that anybody was happy using that term. And people in particular didn't like the idea of somebody managing them, let alone their care.

And I'd say probably nine years later one out of five or six times maybe people use one term rather than the other. Changing people's terms, changing people's thinking

on an issue is a long and slow process. But I think it is important that the second part of your statement is actually not what we're recommending and we hope we can try to get people to understand that that is not our statement.

But we will have to be very careful about how we explain what it is that we are proposing, so that we have a fighting change to have the framework understood and, as the empirical portion is available, have that understood as well.

MS. HELLER: Karen Heller with the Greater New York Hospital Association. Bob, thank you for your comments. I want to think about that a lot.

With respect to the labeling of things, obviously you're considering medical education and allowable costs. There's a difference between allowable and incremental. Allowable to the extent that it's substituting for other things, it's still in the cost base.

I think there's some conceptual appeal to labeling the parts that aren't specifically education as what they really are with respect to the ability to negotiate with private payers and with Medicaid as well. Because IME is so amorphous right now. And because we use resident as a

proxy, people think that it's resident training.

We get so much resistance to that, it would be very helpful if we could find a better proxy or some other way to accurately label it that will appeal to the public, to the other payers.

Actually, a comment that I did want to make, though, is a very, very technical one. As we try to move some of these costs from the IME bucket into the case mix bucket, I think it's also appropriate at this time to fold capital into this discussion, because the transition period is about to end and it's time to certainly have a unified payment for the single unit of care.

DR. WILENSKY: That was certainly the intent, in bringing capital onto prospective payment, that ultimately you would be able to have a single payment rather than separate payments.

On a somewhat lighter note, we are struggling with what to call our enhanced patient care payment. We would like to invite our listening audience that if they have a better term, that they share it with us. We'll decide whether or not there is a reward for this unofficial contest.

DR. LAVE: You should have a site on the web site for people to throw in names. We should give an award, maybe dinner with the commission?

[Laughter.]

DR. WILENSKY: Is that the winners or the losers?

MR. GIBBONS: My name is James Gibbons. I'm here pinch-hitting for Stu Plummer, who's had surgery this week. He's the executive director of the Association for Clinical Pastoral Education. We're among that unnamed group of other health care professionals. We are graduate and post-graduate education, do a lot of the training, most of the training for hospital chaplains around the country, and indeed parts of the world.

I appreciate so many of the values that are expressed and the work that this commission is doing, but especially the focus on the availability of services and the concern about shifting the paradigm in ways that might produce unintended consequences, just like the current paradigm has done the same thing.

So I want to speak from the point of view of our organization, as one of those potential parties affected by the change in the paradigm. If I might cite just a brief

example, until a recent job change for me, I was associated with a hospital in Oak Lawn, Illinois, part of Advocate Health Care, an eight hospital system. It's about 800 beds. Many of the people, of course, that occupy those beds are seniors. Indeed, a disproportionate number of them, related to the population, are there.

In the course of any given year, our staff, approximately half of whom are residents as we use the term, that is to say people in training as graduate or post-graduates. They are doing about 300 to 400 consultations on advanced medical directives every year. They see 500 people and their families who die every year in that particular hospital. They do 400 to 500 ethics based consultations about treatment decisions, ranging from choices patients must confront about whether to embark on a course of treatment or indeed whether to withdraw from treatment or life support or many other aspects that you're quite familiar with.

We have nine ICUs in this particular hospital. A great many of those beds are occupied by seniors, as you would know. And they do require very substantial -- and deserve a very substantial amount of spiritual care and

support.

So let me go to the virtue of the current arrangement and my concern about the future. In the current arrangement of cost recovery, of reimbursement for educational programs, there is some direct tangible support that goes to our training effort and to the services therefore that it provides.

There is a linkage there that is actually quite positive and helpful. If overhead or DRG kinds of reimbursement replace something that is program specific, it is entirely possible that the services that are represented in the now reimbursed programs may also become invisible or disappear.

In other words, there is a constructive linkage between the service provided through the virtue of having an educational program that needs to find some form of remedy in the policy that you're shaping so that we don't throw some of the offspring out with the bath water here.

I haven't heard so far, nor read in your deliberations earlier, how you might propose to not have an unintended consequence of that support, not only for ours but for other similar programs.

DR. WILENSKY: Let me try to respond just briefly to the issue, because it's a much broader issue than the one program that you raise.

There is nothing now in the statute that forces a linkage or a flow-through of the funds that are granted under the so-called education payment to specific programs. The calculation is how the money is calculated that the institution receives, and what happens to funds thereafter. Money mingles, in any case, and what happens to funds is up to institutions in terms of how those specific funds are directed and used.

What we are proposing is to recognize that institutions that have training, such as I would presume the one that you're referencing are, as part of their providing enhanced patient services, subject to increased costs. And we want to recognize those increased costs.

Whether or not the payment will be based on a resident intensity or a number of residents will depend on whether we can find a different way to estimate that relationship. We'd like to, because we'd like to get away from the incentive that the more you have the more money you get, subject to the cap that was introduced in the Balanced

Budget Act. We think that's not a very good incentive.

The point of what I'm saying is that the institutions who have programs such as yours that are part of why these institutions are more expensive, because of the enhanced patient care, will continue to receive more money, either on a per resident basis or not, depending on how clever we are in the estimation and in the vagaries of what the empirical world actually looks like.

And there is no more reason that these institutions can't direct funding toward various activities that have made them more expensive than they did in the past.

What we're trying to recognize is the services being produced that we want to make sure that seniors have access to, that cost more money. And that it is what has been done in a clumsy way, in the past, we are trying to recognize that this is what was going on, but to do it more directly and to hopefully come up with an estimation that has fewer unintended consequences.

The reason I'm saying this is because, as you can imagine, not only have Murray and I received letters from your organization but from a number of others. And we think

that it's important that people understand that, although it may look like we are taking away this education payment, we are more directly doing what we think was intended anyway, which was to make sure that we recognize from Medicare payments that certain kinds of institutions have higher costs. And that either they are recognized in the payment, or that seniors won't be able to go there. And that allows for an appropriate recognition.

And we may or may not be able to do it without the unintended consequences of encouraging more residents to be a part of the program, which we don't think was ever intended. It was just a fallout at the time of the payment to the basis that was used for payment.

So again, we will have to work very hard in our written document to try to make it understood how people had talked about the issue before, what we thought was really happening with the money, however they spoke about it, how we are trying to get people to think about it, and what we think the consequences of doing it this way will be for institutions. And we will see whether we can try to make sure all of us as commissioners, when we are explaining what it is we are proposing, we'll all be in the position of

having to do that, of wanting to do that, that we also have a way to try to explain what it is we're proposing and why, and what we think the consequences of moving to this system are.

But I think it will be very important that the notion, either that we were really paying for education in the past be put to rest, or that we're not paying for the increased costs associated with institutions that do train, also we hope will be put to rest. But we'll see.

MS. TODD: I'm Greta Todd with the American Association of Nurse Anesthetists.

I wanted to just, first of all, thank you for your work and I look forward to seeing your report at the end of this exploration.

I wanted to just raise one issue that was briefly brought up, I think by Dr. Wakefield, and just briefly discuss. I really want to urge the commission to thoroughly explore and examine the role of non-physician providers in this new framework. There are many health care professionals who add both value and cost, in the course of their training, to the Medicare beneficiaries' care.

So we're really urging that you fully examine

this. There are hundreds of thousands of Medicare beneficiaries, as you know, who receive care from non-M.D. providers, especially in rural areas. And to neglect their role in the system would have probably a very negative impact on not only the beneficiaries but also the hospitals and the providers.

So I would encourage you to look at that. Thank you.

DR. WILENSKY: Thank you.

Any other comments?

DR. WAKEFIELD: I'm still trying to learn the patterns here, Gail. I'll get it by the next time.

DR. WILENSKY: Normally we don't respond to comments from the public. This has obviously been a special issue, in terms of the interest and the amount of time that we have devoted to it.

DR. WAKEFIELD: I just wanted to ask a question and I missed my opportunity earlier.

In part of the text in the document on page six, we talk about using a team approach in providing care in ambulatory care settings and an acknowledgement of the attending physician and resident both providing care, et

cetera.

The question that I have actually relates to team defined more broadly, and that is interdisciplinary teams. If care was provided by an interdisciplinary team, so we're in a training situation but there's enhanced patient care that costs more, so enhanced patient services -- again, an interdisciplinary team. I'm not talking just about this more narrow application of the word team.

Would that be a set of circumstances that might qualify for enhanced payment, if it meets those criteria?

DR. WILENSKY: If we can figure out to measure it.

DR. WAKEFIELD: There is the problem, I know.

DR. WILENSKY: No, in principle, my sense is yes.

DR. WAKEFIELD: It would seem to me, in the application of those criteria, that would be the case. I wanted to validate that. Thanks.

DR. WILENSKY: If there are no further comments, we will be distributing the paper to commissioners as soon as it is available. You will be notified as to how much time you have for comment.

We will be meeting again around mid-September. We will obviously give you information prior to that, as well

as the paper. Any comments that you want to make, just make sure that you remember the short timeline we're under.

[Whereupon, at 3:07 p.m., the meeting was adjourned.]

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